ALABAMA STATE COMMITTEE OF PUBLIC HEALTH
DIVISION OF LICENSURE AND CERTIFICATION
ADMINISTRATIVE CODE

CHAPTER 420-5-10
NURSING FACILITIES

TABLE OF CONTENTS

420-5-10-.01	Definitions
420-5-10-.02	Licensing and Administrative Procedures
420-5-10-.03	Administrative Management
420-5-10-.04	Personnel
420-5-10-.05	Resident Rights
420-5-10-.06	Freedom from Abuse, Neglect, Misappropriation, and Exploitation
420-5-10-.07	Admission, Transfer, and Discharge
420-5-10-.08	Resident Assessment
420-5-10-.09	Comprehensive Person-Centered Care Planning
420-5-10-.10	Quality of Life
420-5-10-.11	Quality of Care
420-5-10-.12	Physician Services
420-5-10-.13	Nursing Services
420-5-10-.14	Behavioral Health
420-5-10-.15	Pharmacy Services
420-5-10-.16	Laboratory, Radiology, and Other Diagnostic Services
420-5-10-.17	Dental Services
420-5-10-.18	Food and Nutrition Services
420-5-10-.19	Specialized Rehabilitative Services
420-5-10-.20	Quality Assurance and Performance Improvement (QAPI) Program
420-5-10-.21	Infection Control
420-5-10-.22	Compliance and Ethics Program
420-5-10-.23	Physical Plant and Environment
420-5-10-.24	Training Requirements

420-5-10-.01 Definitions.

(1) Definitions - (a list of selected terms often used in connection with these rules):

(a) "Abuse" - The willful infliction of injury, unreasonable confinement, intimidation, or punishment with resulting physical harm, pain, or mental anguish. Abuse also includes the deprivation by an individual, including a caretaker, of goods or services that are necessary to attain or maintain physical,

mental, and psychosocial well-being. Instances of abuse of all residents, irrespective of any mental or physical condition, cause physical harm, pain, or mental anguish. It includes verbal abuse, sexual abuse, physical abuse, and mental abuse including abuse facilitated or enabled through the use of technology.

(b) "Accident" - Refers to any unexpected or unintentional incident, which results or may result in injury or illness to a resident. This does not include other types of harm, such as adverse outcomes that are a direct consequence of treatment or care that is provided in accordance with current professional standards of practice (e.g., drug side effects or reaction).

1) "Avoidable accident" - An accident occurred because the facility failed to:

a. Identify environmental hazards and/or assess individual resident risk of an accident, including the need for supervision and/or assistive devices, and/or

b. Evaluate *and* analyze the hazards and risks and eliminate them, if possible, or, if not possible, identify and implement measures to reduce the hazards/risks as much as possible, and/or

c. Implement interventions, including adequate supervision and assistive devices, consistent with a resident's needs, goals, care plan, and current professional standards of practice in order to eliminate the risk, if possible, and, if not, reduce the risk of an accident, and/or

d. Monitor the effectiveness of the interventions and modify the care plan as necessary, in accordance with current professional standards of practice.

2) "Unavoidable accident" - An accident occurred despite sufficient and comprehensive facility systems designed and implemented to:

a. Identify environmental hazards and individual resident risk of an accident, including the need for supervision.

b. Evaluate *and* analyze the hazards and risks and eliminate them, if possible and, if not possible, reduce them as much as possible.

c. Implement interventions, including adequate supervision, consistent with the resident's needs, goals, plan of care, and current professional standards of practice in order to *eliminate the risk, if possible, and, if not,* reduce the risk of an accident.

d. Monitor the effectiveness of the interventions and modify the interventions as necessary, in accordance with current professional standards of practice.

(c) "Activities" - Refers to any endeavor, other than routine activities of daily living (ADLs), in which a resident participates that is intended to enhance her/his sense of well-being and to promote or enhance physical, cognitive, and emotional health. These include, but are not limited to activities that promote self-esteem, pleasure, comfort, education, creativity, success, and independence.

(d) "Administrator" - A person who holds a valid Alabama Nursing Home Administrator's License who is delegated the responsibility and authority for the interpretation, implementation, and proper application of policies and programs established by the governing body. The Administrator is delegated responsibility for the establishment of safe and effective administrative management, control, and operation of the services provided.

(e) "Advance care planning" - A process of communication between individuals and their healthcare agents to understand, reflect on, discuss, and plan for future healthcare decisions for a time when individuals are not able to make their own healthcare decisions.

(f) "Advance directive" - "A written instruction, such as a living will or durable power of attorney for healthcare, recognized under state law (whether statutory or as recognized by the courts of the state), relating to the provision of healthcare when the individual is incapacitated." See 42 C.F.R. §489.100.

(g) “All rules and regulations” - State and federal requirements and facility policies.

(h) “Alleged violation” - A situation or occurrence that is observed or reported by staff, resident, relative, visitor, another healthcare provider, or others but has not yet been investigated and, if verified, could be noncompliant with the federal requirements related to mistreatment, exploitation, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property.

(i)"Applicant" - The person, partnership, corporation, association, city, county, or other organization legally responsible for operation of the facility.

(j) "Assisted living facility" - A facility as defined in the Rules of Alabama State Committee of Public Health, Chapter 420-5-4.

(k) ”Attending physician” - The primary physician who is responsible for managing the resident’s medical care. This does not include other physicians whom the resident may see periodically, such as specialists.

(l) “Basic life support” - A level of medical care which is used for victims of life-threatening illnesses or injuries until they can be given full medical care at a hospital, and may include recognition of sudden cardiac arrest, activation of the emergency response system, early cardiopulmonary resuscitation, and rapid defibrillation with an automated external defibrillator, if available.

(m) “Bed rails” - Adjustable metal or rigid plastic bars that attach to the bed. They are available in a variety of types, shapes, and sizes ranging from full to one-half, one-quarter, or one-eighth lengths. Also, some bed rails are not designed as part of the bed by the manufacturer and may be installed on or used along the side of a bed. Examples of bed rails include, but are not limited to: side rails, bed side rails, and safety rails; and grab bars and assist bars.

(n) “Cardiopulmonary resuscitation (CPR)” - Any medical intervention used to restore circulatory and/or respiratory function that has ceased.

(o) “Clinically significant” - Refers to effects, results, or consequences that materially affect or are likely to affect

an individual's physical, mental, or psychosocial well-being either positively by preventing, stabilizing, or improving a condition or reducing a risk, or negatively by exacerbating, causing, or contributing to a symptom, illness, or decline in status.

(p) "Code status" – Refers to the level of medical interventions a person wishes to have started if their heart or breathing stops.

(q) "Combination facility" - A facility which provides more than one level of care and is licensed under one license, e.g., general hospital and skilled nursing facility, skilled nursing facility, and assisted living facility.

(r) "Communicable" - Conditions that are capable of being transmitted from one person to another. For reporting purposes, nursing facilities shall refer to the Notifiable Diseases on the Alabama Department of Public Health website at Communicable Diseases | Alabama Department of Public Health (ADPH): www.alabamapublichealth.gov/bcd

(s) "Comprehensive assessment" - Includes the completion of the Minimum Data Set (MDS) as well as the Care Area Assessment (CAA) process, followed by the development and/or review of the comprehensive care plan. Comprehensive MDS assessments include Admission, Annual, Significant Change in Status Assessment, and Significant Correction to Prior Comprehensive Assessment.

(t) "Continence" - Refers to any void that occurs voluntarily, or as the result of prompted, assisted, or scheduled use of the bathroom.

(u) "Covered individual" - Anyone who is an owner, operator, employee, manager, agent, or contractor of the facility.

(v) "Dialysis facility" - An entity that provides outpatient maintenance dialysis services or home dialysis training and support services, or both.

(w) "Dentist" - A person currently licensed to practice dentistry in Alabama under the provisions of current state statutes.

(x) "Director of Food and Nutrition Services/Dietary Manager" - An individual who is an employee, and if not a qualified dietitian, is one who:

1) Is a graduate of a dietary manager's training program, approved by the Dietary Manager's Association, or

2) Is a graduate of a dietetic technician program approved by the American Dietetic Association, or

3) Is a graduate from a college or university who has received a B.S. degree in the field of dietetics, food and nutrition or food service management which included course work in diet therapy and quantity food production, or

4) Has similar national certification for food service management and safety from a national certifying body (Servsafe, the food safety manager program is accredited by the American National Standards Institute and would meet the requirement of food service management).

(y) "Discharge Planning"- A process that generally begins on admission and involves identifying each resident's discharge goals and needs, developing and implementing interventions to address them, and continuously evaluating them throughout the resident's stay to ensure a successful discharge.

(z) "Do Not Resuscitate (DNR) Order" - Refers to a medical order issued by a physician or other authorized non-physician practitioner that directs healthcare providers not to administer CPR in the event of cardiac or respiratory arrest. Existence of an advance directive does not imply that a resident has a DNR order. The medical record should show evidence of documented discussions leading to a DNR order.

(aa) "Experimental research" - The development, testing, and use of a clinical treatment, such as an investigational drug or therapy that has not yet been approved by the federal Food and Drug Administration (FDA) or medical community as effective and conforming to accepted medical practice.

(bb) "Exploitation" - Taking advantage of a resident for personal gain, through the use of manipulation, intimidation, threats, or coercion.

(cc) "Facility-Initiated transfer or discharge"- A transfer or discharge which the resident objects to, or did not originate through a resident's verbal or written request,

and/or is not in alignment with the resident's stated goals for care and preferences.

(dd) "Fall" - Refers to unintentionally coming to rest on the ground, floor, or other lower level, but not as a result of an overwhelming external force (e.g., resident pushes another resident). An episode where a resident lost his/her balance and would have fallen, if not for another person or if he or she had not caught him/herself, is considered a fall. A fall without injury is still a fall. Unless there is evidence suggesting otherwise, when a resident is found on the floor, a fall is considered to have occurred (refer to Resident Assessment Instrument User's Manual. Version 3.0, Chapter 3, page J-27).

(ee) "Finding" - A determination made by the state that validates allegations of abuse, neglect, exploitation, mistreatment of residents, or misappropriation of their property.

(ff) "Fully sprinklered" – A long term care facility that has all areas sprinkled in accordance with National Fire Protection Association 13 "Standard for the Installation of Sprinkler Systems" without the use of waivers of the Fire Safety Code.

(gg) "Governing body" - Owner(s), hospital association, county hospital board, board of directors, board of trustees, or any other comparable designation of an individual or group of individuals who have the purpose of owning, acquiring, constructing, equipping, operating, and/or maintaining a nursing facility and exercising control over the affairs of said nursing facility.

(hh) "Hazards" - Elements of the resident environment that have the potential to cause injury or illness. "Hazards over which the facility has control" are those hazards in the resident environment where reasonable efforts by the facility could influence the risk for resulting injury or illness. "Free of accident hazards as is possible" refers to being free of accident hazards over which the facility has control.

(ii) "Healthcare decision-making capacity" - Possessing the ability (as defined by state law) to make decisions regarding healthcare and related treatment choice.

(jj) "Healthcare provider" - Includes a physician, physician assistant, or nurse practitioner. The term also includes a qualified dietitian or other qualified nutrition professional who is acting within their state scope of practice and to whom the attending physician has delegated tasks suitable for dietitians.

(kk) "Highest practicable physical, mental, and psychosocial well-being" - The highest possible level of functioning and well-being, limited by the individual's recognized pathology and normal aging process. Highest practicable is determined through the comprehensive resident assessment and by recognizing and competently and thoroughly addressing the physical, mental, or psychosocial needs of the individual.

(ll) "Homelike environment"- Is one that de-emphasizes the institutional character of the setting, to the extent possible, and allows the resident to use those personal belongings that support a homelike environment. A determination of "homelike" should include the resident's opinion of the living environment.

(mm) "Home dialysis" - Dialysis performed at home by an end-stage renal disease (ESRD) patient or caregiver who has completed an appropriate course of training as described in §494.100(a) of this part.

(nn) "Hospital" - A facility as defined in the Rules of Alabama State Committee of Public Health, Chapter 420-5-7.

(oo) "In a language that the resident understands" means verbally, in writing, and in a language that is clear and understandable to the resident and/or his or her representative.

(pp) "Independent clinical laboratory" - A facility as defined in the Rules of Alabama State Committee of Public Health, Chapter 420-5-8.

(qq) "Injuries of unknown source" – An injury should be classified as an "injury of unknown source" when all of the following criteria are met: *The source of the injury was not observed by any person;* and the source of the injury could not be explained by the resident; and the injury is suspicious because of the extent of the injury or the location of the injury (e.g., the injury is located in an area not generally vulnerable to trauma) or the number of

injuries observed at one particular point in time or the incidence of injuries over time.

(rr) "Inpatient rehabilitation facility (IRF)"- Freestanding rehabilitation hospitals or rehabilitation units in acute care hospitals that serve an inpatient population requiring intensive services for treatment.

(ss) "Intellectual disability (ID)" - An individual is considered to have ID if he or she has:

1) A level of retardation (mild, moderate, severe or profound) described in the American Association on Intellectual's Disability Manual on Classification in Intellectual Disability (1983); or

2) A related condition as defined by §435.1010 of the Code of Federal Regulations.

(tt) "Interventions" - Actions, treatments, procedures, or activities designed to meet an objective.

(uu) "Intravenous (IV) therapy" - the administration of parenteral fluids or medications through an IV catheter to treat a condition.

(vv) "Involuntary seclusion" - Separation of a resident from other residents or from her/his room or confinement to her/his room (with or without roommates) against the resident's will, or the will of the resident representative.

(ww) "Local contact agency" - Refers to each state's designated community contact agencies that can provide individuals with information about community living options and available support and services. These local contact agencies may be a single entry point agency, such as an Aging and Disability Resource Center (ADRC), an Area Agency on Aging (AAA), a Center for Independent Living (CIL), or other state designated entities.

(xx) "License" - The document issued by the State Committee of Public Health and signed by the State Health Officer. The license shall constitute the authority to receive residents and perform the services included within the scope of the applicable rules. The license shall be posted in a conspicuous place on the premises.

(yy) “Licensed health professional” - A licensed health professional is a physician; physician assistant; nurse practitioner; physical, speech, or occupational therapist; physical or occupational therapy assistant; registered professional nurse; licensed practical nurse; or licensed or certified social worker; or registered respiratory therapist or certified respiratory therapy technician.

(zz) "Licensed practical nurse" - A person currently licensed in the state of Alabama in accordance with the *Code of Alabama*.

(aaa) "Licensee" - The individual owner, partnership, corporation, association, city, county, or other organization to whom the license is issued and upon whom rests the responsibility for compliance with these rules.

(bbb) "Long term care" - Prolonged care of residents in licensed institutions and/or organized departments within a licensed institution where the average length of resident stay is 25 days or longer.

(ccc) “Long term care Hospital (LTCH)”- Are certified as acute-care hospitals, but focus on patients who, on average, stay more than 25 days. Many of the patients in LTCHs are transferred there from an intensive or critical care unit. LTCHs specialize in treating patients who may have more than one serious condition, but who may improve with time and care, and return home.

(ddd) “Major modification” – The modification of more than 50 percent, or more than 4.500 square feet, of the smoke compartment.

(eee) “Manual method” - To hold or limit a resident’s voluntary movement by using body contact as a method of physical restraint.

(fff) "May" - Indicates permission.

(ggg) “Medical staff" - Licensed physicians, osteopaths, and dentists who are privileged by agreement with the licensee to attend to residents within the institution.

(hhh) “Medication assistant, certified (MAC)” - A medication assistant, certified through an Alabama State Board of Nursing approved program and the Medication Assistant Certification Exam (MACE) may perform limited medication

administration tasks in a licensed healthcare facility other than a mental health residential community program or K-12 grade school program.

(iii) "Medication assisted treatment" (MAT) - The use of medications, in combination with counseling and behavioral therapies, to provide a "whole-patient" approach to the treatment of substance use disorders. (From the Substance Abuse and Mental Health Services Administration [SAMHSA]).

(jjj) "Medical symptom" - An indication or characteristic of a medical, physical, or psychological condition.

(kkk) "Medicine or drug room" - A specific area, not subject to licensure by the Alabama State Board of Pharmacy, in a licensed nursing facility, used for the purpose of storing and/or preparing medications for administration and equipment necessary to administer medications to the residents of that facility.

(lll) "Minimum data set (MDS)"- Is part of the U.S. federally mandated process for clinical assessment of all residents in Medicare or Medicaid-certified nursing homes. It is a core set of screening, clinical and functional status elements, including common definitions and coding categories, which forms the foundation of a comprehensive assessment.

(mmm) "Misappropriation of resident property" - The deliberate misplacement, exploitation, or wrongful, temporary, or permanent use of a resident's belongings or money without the resident's consent.

(nnn) "Mistreatment" - Inappropriate treatment or exploitation of a resident.

(ooo) "Mobility" - All types of movement including walking, movement in a bed, transferring from a bed to a chair, all with or without assistance or moving about an area either with or without an appliance (chair, walker, cane, crutches, etc.).

(ppp) "Must be seen" - For purposes of the visits required by §483.30(c)(1), means that the physician or non-physician practitioner (NPP) must make actual face-to-face contact with the resident, and at the same physical location, not via a telehealth arrangement. There is no requirement for this type of contact at the time of admission, since the decision to

admit an individual to a nursing facility (whether from a hospital or from the individual's own residence) generally involves physician contact during the period immediately preceding the admission.

(qqq) "A need to alter treatment significantly" - A need to stop a form of treatment because of adverse consequences (such as an adverse drug reaction) or commence a new form of treatment to deal with a problem (for example, the use of any medical procedure, or therapy that has not been used on that resident before).

(rrr) "Neglect" - The failure of the facility, its employees or service providers to provide goods and services to a resident that are necessary to avoid physical harm, pain, mental anguish or emotional distress.

(sss) "Noninvasive ventilation (NIV)" - The administration of ventilatory support without using an invasive artificial airway (endotracheal tube or tracheostomy tube).

(ttt) "Non-physician practitioner (NPP)" - A nurse practitioner (NP) or physician assistant (PA).

(uuu) "Nurse aide" - Any individual providing nursing or nursing-related services to residents in a facility. This term may also include an individual who provides these services through an agency or under a contract with the facility, but is not a licensed health professional, a registered dietitian, or someone who volunteers to provide such services without pay. Nurse aides do not include those individuals who furnish services to residents only as paid feeding assistants as defined in § 488.301.

(vvv) "Nurse practitioner (NP)" - A registered professional nurse currently licensed to practice in the state, operating pursuant to a valid collaborative practice agreement with a licensed physician, and who meets the state's requirements governing the qualification of NPs who:

1) Is currently certified as a primary care NP by the American Nurses Association or by the National Board of Pediatric Nurse Practitioners and Associates; or

2) Has satisfactorily completed a formal 1 academic year educational program that:

a) Prepares registered nurses to perform an expanded role in the delivery of primary care;

b) Includes at least 4 months (in the aggregate) of classroom instruction and a component of supervised clinical practice; and

c) Awards a degree, diploma, or certificate to persons who successfully complete the program; or

3) Has successfully completed a formal educational program (for preparing registered nurses to perform an expanded role in the delivery of primary care) that does not meet the requirements above and has been performing an expanded role in the delivery of primary care for a total of 12 months during the 18-month period immediately preceding September 22, 2006.

(www) "Nursing facility" – A business entity that is engaged in providing housing, meals, and care to sick or disabled individuals who require, on a daily basis or more frequently, medical care, nursing care, or inpatient or outpatient rehabilitation services or other healthcare services required by the resident. This definition shall not include any business, operation, or facility that is exempt from licensure pursuant to Alabama law, nor shall it include any business, operation, or facility that is

(1) licensed by the Alabama State Committee of Public Health as another kind of facility, and

(2) functioning within the scope of applicable law and administrative rules.

(xxx) "Nursing graduate" – Refer to the Alabama Board of Nursing Administrative Code, Chapter 610-X-4-.04, the use of the title Nursing Graduate-PN Program (NG-PNP) or Nursing Graduate-RN Program (NG-RNP).

(yyy) "Nutritional status" - Includes both nutrition and hydration status.

(zzz) "Nutritional supplements" - Products that are used to complement a resident's dietary needs (e.g., calorie or nutrient dense drinks, total parenteral products, enteral products, and meal replacement products).

(aaaa) “Orderly” - An uncluttered physical environment that is neat and well-kept.

(bbbb) "Owner" - The person, partnership, corporation, association, city, county, or other entity who through asset ownership, lease, or sublease is entitled to responsibility for and control of operation of the facility.

(cccc) “Palliative Care” - Patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and to facilitate patient autonomy, access to information, and choice.

(dddd) “Passive range of motion (ROM)” - The movement of a joint through the range of motion with no effort from the patient.

(eeee) “Patient assessment data”- Standardized, publicly available information derived from a post-acute care provider’s patient/resident assessment instrument, e.g., Minimum Data Set (MDS), Outcome and Assessment Information Set (OASIS).

(ffff) “Person-centered care” - To focus on the resident as the locus of control and support the resident in making their own choices and having control over their daily lives.

(gggg) “Persons with Related Conditions” - Persons with related conditions means individuals who have a severe, chronic disability that meets all the following conditions:

1) It is attributable to:

   a) Cerebral palsy or epilepsy; or

   b) Any other condition, other than a mental illness, found to be closely related to ID because this condition results in impairment of general intellectual functioning or adaptive behavior similar to that of mentally retarded persons and requires treatment or services similar to those required for these persons.

2) It is manifested before the person reaches age 22.

3) It is likely to continue indefinitely.

4) It results in substantial functional limitations in three or more of the following areas of major life activity:

a) Self-care.

b) Understanding and use of language.

c) Learning.

d) Mobility.

e) Self-direction.

f) Capacity for independent living.

(hhhh) "Pharmacist" - A person currently licensed to practice pharmacy in Alabama under the provisions contained in current state statutes and rules of the Alabama State Board of Pharmacy.

(iiii) "Pharmacist consultant" - A person currently licensed and registered by the Alabama State Board of Pharmacy to provide consultative services as defined by current state statutes and rules of the Alabama State Board of Pharmacy.

(jjjj) "Pharmacy" - A place licensed by the Alabama State Board of Pharmacy in which prescriptions, drugs, medicines, chemicals, and poisons are sold, offered for sale, compounded or dispensed, and shall include all places whose title may imply the sale, offering for sale, compounding or dispensing of prescription drugs, medicines, chemicals, or poisons or the storage of such items.

(kkkk) “Physical restraint” - Any manual method, physical or mechanical device, equipment, or material that meets all of the following criteria:

1) Is attached or adjacent to the resident’s body;

2) Cannot be removed easily by the resident; and

3) Restricts the resident’s freedom of movement or normal access to his/her body.

(llll) "Physician assistant" - A person who is currently licensed by the Alabama State Board of Medical Examiners as a physician assistant, operating pursuant to a valid supervisory agreement with a licensed physician, who:

1) Is currently certified by the National Commission on Certification of Physician Assistants to assist physicians; or

2) Has satisfactorily completed a program for preparing physician's assistants that was at least 1 academic year in length; consisted of supervised clinical practice and at least 4 months (in the aggregate) of classroom instruction directed toward preparing students to deliver healthcare; and was accredited by the American Medical Association's Committee on Allied Health Education and Accreditation; or

3) Has satisfactorily completed a formal educational program (for preparing physician assistants) that does not meet the requirements above and has been assisting physicians for a total of 12 months during the 18-month period that ended on December 31, 1986.

(mmmm) "Physician orders for life-sustaining treatment (POLST) paradigm form" - A form designed to improve patient care by creating a portable medical order form that records patients' treatment wishes so that emergency personnel know what treatments the patient wants in the event of a medical emergency, taking the patient's current medical condition into consideration. A POLST paradigm form is not an advance directive.

(nnnn) "Position change alarms" – Alerting devices intended to monitor a resident's movement. The devices emit an audible signal when the resident moves in a certain way. Types of position change alarms include chair and bed sensor pads, bedside alarmed mats, alarms clipped to a resident's clothing, seatbelt alarms, and infrared beam motion detectors. Position change alarms do not include alarms intended to monitor for unsafe wandering such as door or elevator alarms.

(oooo) "Preadmission screening and resident review (PASARR)" – A federal requirement to help ensure that individuals who have a mental disorder (MD) or intellectual disabilities (IDs) are not inappropriately placed in nursing homes for

long term care. PASARR requires all applicants to a Medicaid-certified nursing facility:

1) Be evaluated for a serious mental disorder and/or intellectual disability;

2) Be offered the most appropriate setting for their needs (in the community, a nursing facility, or acute care setting); and

3) Receive the services they need in those settings.

(pppp) "Pressure ulcer/injury (PU/PI)" - Localized damage to the skin and/or underlying soft tissue usually over a bony prominence or related to a medical or other device. A pressure injury will present as intact skin and may be painful. A pressure ulcer will present as an open ulcer, the appearance of which will vary depending on the stage and may be painful. The injury occurs as a result of intense and/or prolonged pressure or pressure in combination with shear. *S*oft tissue damage related to pressure and shear may also be affected by skin temperature and moisture, nutrition, perfusion, co-morbidities, and condition of the soft tissue.

(qqqq) The following definitions apply to pressure ulcers and/or pressure injuries described above in (pppp):

1) Avoidable/unavoidable

a) "Avoidable" means that the resident developed a PU/PI, and that the facility did not do one or more of the following:

(i) Evaluate the resident's clinical condition and risk factors;

(ii) Define and implement interventions that are consistent with resident needs, resident goals, and professional standards of practice;

(iii) Monitor and evaluate the impact of the interventions; or

(iv) Revise the interventions as appropriate.

b) "Unavoidable" means that the resident developed a PU/PI even though the facility had;

(i) Evaluated the resident's clinical condition and risk factors;

(ii) Defined and implemented interventions that are consistent with resident needs, goals, and professional standards of practice;

(iii) Monitored and evaluated the impact of the interventions; and

(iv) Revised the approaches as appropriate.

2) Colonized/infected

a) "Colonized" refers to the presence of micro-organisms on the surface or in the tissue of a wound without the signs and symptoms of an infection.

b) "Infected" refers to the presence of micro-organisms in sufficient quantity to overwhelm the defenses of viable tissues and produce the signs and symptoms of infection.

3) Debridement - The removal of devitalized/necrotic tissue and foreign matter from a wound to improve or facilitate the healing process. Debridement methods may include a range of treatments such as the use of enzymatic dressings to surgical debridement in order to remove tissue or matter from a wound to promote healing.

4) Eschar/slough

a) "Eschar" is dead or devitalized tissue that is hard or soft in texture; usually black, brown, or tan in color, and may appear scab-like. Necrotic tissue and eschar are usually firmly adherent to the base of the wound and often the sides/edges of the wound.

b) "Slough" is non-viable yellow, tan, gray, green, or brown tissue; usually moist, can be soft, stringy, and mucinous in texture. Slough may be adherent to the base of the wound or present in clumps throughout the wound bed.

5) Exudate is any fluid that has been forced out of the tissues or its capillaries because of inflammation or

injury. It may contain serum, cellular debris, bacteria, and leukocytes.

a) "Purulent exudate/drainage/discharge" is any product of inflammation that contains pus (e.g., leukocytes, bacteria, and liquefied necrotic debris).

b) "Serous drainage or exudate" is watery, clear, or slightly yellow/tan/pink fluid that has separated from the blood and presents as drainage.

6) Friction/Shearing

a) "Friction" is the mechanical force exerted on skin that is dragged across any surface.

b) "Shearing" occurs when layers of skin rub against each other or when the skin remains stationary, and the underlying tissue moves and stretches and angulates or tears the underlying capillaries and blood vessels causing tissue damage.

7) Granulation tissue - The pink-red moist tissue that fills an open wound when it starts to heal. It contains new blood vessels, collagen, fibroblasts, and inflammatory cells.

8) Tunnel/Sinus Tract/Undermining - The terms tunnel and sinus tract are often used interchangeably.

a) A "tunnel" is a passageway of tissue destruction under the skin surface that has an opening at the skin level from the edge of the wound.

b) A "sinus tract" is a cavity or channel underlying a wound that involves an area larger than the visible surface of the wound.

c) "Undermining" is the destruction of tissue or ulceration extending under the skin edges (margins) so that the pressure ulcer is larger at its base than at the skin surface. Undermining often develops from shearing forces and is differentiated from tunneling by the larger extent of the wound edge involved and the absence of a channel or tract

extending from the pressure ulcer under the adjacent intact skin.

(rrrr) "Psychosocial adjustment difficulty" - The development of emotional and/or behavioral symptoms in response to an identifiable stressor(s) that have not been the resident's typical response to stressors in the past or an inability to adjust to stressors as evidenced by chronic emotional and/or behavioral symptoms. (Adapted from Diagnostic and Statistical Manual of Mental Disorders - Fifth edition. 2013, American Psychiatric Association.)

(ssss) "Qualified dietetic consultant" - A person who is eligible for registration by the Commission on Dietetic Registration (CDR), has at least 1 year of full-time experience in the dietetic service of a healthcare institution in a supervisory capacity, or has satisfactorily completed the test for registration administered by CDR and meets the annual requirements in continuing education required by CDR.

(tttt) "Qualified dietitian" – A person currently licensed in the state of Alabama in accordance with the provisions contained in current state statutes as governed by the Alabama Board of Examiners for Dietetic/Nutrition Practice.

(uuuu) "Qualified therapist" – Professional staff, licensed, certified or registered to provide specialized therapy and/or rehabilitative services in accordance with state laws. Includes: Physical, occupational, and respiratory therapists and speech-language pathologists.

(vvvv) "Quality of life" - An individual's "sense of well-being, level of satisfaction with life and feeling of self-worth and self-esteem. For nursing home residents, this includes a basic sense of satisfaction with oneself, the environment, the care received, the accomplishments of desired goals, and control over one's life."

(wwww) "Quarterly review assessment" - Is a required, non-comprehensive assessment pursuant to the Omnibus Budget Reconciliation Act of 1987 (OBRA '87). It must be completed at least every 92 days following a previous OBRA assessment of any type. It is used to track a resident's status between comprehensive assessments to ensure critical indicators of gradual change in a resident's status are monitored. As such, not all MDS items appear on the quarterly assessment.

(xxxx) "Range of motion (ROM)"- The full movement potential of a joint.

(yyyy) "Reasonable access" - Telephones, computers and other communication devices are easily accessible to residents and are adapted to accommodate resident's needs and abilities, such as hearing or vision loss.

(zzzz) "Reasonable accommodation of resident needs and preferences" - The facility's efforts to individualize the resident's physical environment.

(aaaaa) "Recapitulation of stay"- A concise summary of the resident's stay and course of treatment in the facility.

(bbbbb) "Reconciliation of medications"- A process of comparing pre-discharge medications to post-discharge medications by creating an accurate list of both prescription and over the counter medications that includes the drug name, dosage, frequency, route, and indication for use for the purpose of preventing unintended changes or omissions at transition points in care.

(ccccc) "Registered nurse" - A person registered and currently licensed in the state of Alabama in accordance with the provisions contained in current state statutes.

(ddddd) "Rehabilitation" - An organized or well-defined program of therapeutics designed to help residents overcome physical, social, vocational, or economic limitations as a result of a disability. Rehabilitation includes helping residents to reach the highest functional level of physical, psychological and socio-economic adjustment compatible with their disability.

(eeeee) "Rehabilitative services for MD or ID" - Refers to those services of lesser frequency or intensity to be implemented by all levels of nursing facility staff that come into contact with any resident who has a mental disorder or an intellectual disability. These services are necessary regardless of whether or not they are specified in the PASARR Level II documents and whether or not the resident requires additional services to be provided or arranged for by the state.

(fffff) "Resident" - A person admitted to a nursing facility by and upon the order of a physician.

(ggggg) "Resident activities consultant" - A person who:

1) Is registered or meets requirements for registration as a professional level therapeutic recreation specialist by a recognized accrediting body; or

2) Is a qualified occupational therapist or occupational therapy assistant; or

3) Has 2 years of experience in a social or recreational program within the past 5 years, 1 year of which was full time in a resident activities program in a healthcare setting; or

4) Has completed a training course approved by the state.

(hhhhh) "Resident activities coordinator" - A person who is registered or meets the requirements for a resident activities consultant or a person who serves under the supervision of a qualified resident activities consultant or has the equivalent of 2 years of full-time experience, under the supervision of a qualified resident activities consultant.

(iiiii) “Resident assessment instrument (RAI)” - Consists of three basic components: MDS version 3.0; CAA process; and the RAI utilization guidelines. The utilization of these components of the RAI yields information about a resident’s functional status, strengths, weaknesses, and preferences, as well as offering guidance on further assessment once problems have been identified.

(jjjjj) “Resident representative” - May mean any of the following:

1) An individual chosen by the resident to act on behalf of the resident to support the resident in decision-making; access medical, social, or other personal information of the resident; manage financial matters; or receive notifications; or

2) A person authorized by state or federal law (including but not limited to agents under power of attorney, representative payees, and other fiduciaries) to act on behalf of the resident in order to support the resident in decision-making; access medical, social, or

other personal information of the resident; manage financial matters; or receive notifications; or

3) Legal representative, as used in section 712 of the Older Americans Act; or

4) The court-appointed guardian or conservator of a resident.

Nothing in this rule is intended to expand the scope of authority of any resident representative beyond that authority specifically authorized by the resident, state or federal law, or a court of competent jurisdiction.

(kkkkk) "Respiratory therapy service" - Services that are provided by a qualified professional (respiratory therapists, respiratory nurse) for the assessment, treatment, and monitoring of residents with deficiencies or abnormalities of pulmonary function (*See,* 42 CFR §483.65, Specialized Rehabilitative Services).

(llllll) "Serious bodily injury" - An injury involving extreme physical pain; involving substantial risk of death; involving protracted loss or impairment of the function of a bodily member, organ, or mental faculty; requiring medical intervention such as surgery, hospitalization, or physical rehabilitation; or an injury resulting from criminal sexual abuse (*See*, 42 U.S.C. § 1397j(19)(A) and 42 U.S.C. § 1397j(19)(B)).

(mmmmm) "Sexual abuse" - Non-consensual sexual contact of any type with a resident.

(nnnnn) "Shall" - Mandatory requirements.

(ooooo) "Significant change in status assessment (SCSA)" – A comprehensive assessment that must be completed when the Interdisciplinary Team (IDT) has determined that a resident meets the significant change guidelines for either major improvement or decline.

(ppppp) "Significant Change" - A major decline or improvement in a resident's status that 1) will not normally resolve itself without intervention by staff or by implementing standard disease-related clinical interventions; the decline is not considered self-limiting (NOTE: Self-limiting is when the condition will normally resolve itself without further intervention or by staff implementing standard clinical

interventions to resolve the condition.); 2) impacts more than one area of the resident's health status; and 3) requires interdisciplinary review and/or revision of the care plan.

(qqqqq) "Social service consultant" - An individual who meets the requirements of and is certified by the State of Alabama Board of Social Work Examiners.

(rrrrr) "Social service designee" - A person employed by a facility with less than 120 beds on a full-time basis to meet the social service needs of residents. These persons must have a minimum of a G.E.D. or High School Diploma and have experience in dealing with the public.

(sssss) "Social worker" - A person who has either a Baccalaureate of Social Work or Master of Social Work degree and is licensed in accordance with the *Code of Alabama*.

(ttttt) "Special focus facility" (SFF) – A federally certified nursing facility that has been identified as one with a noteworthy history of poor performance and is involuntarily enrolled in a special program with increased oversight and enhanced enforcement activity designed to stimulate improvements in quality of care and quality of life. Once selected as an SFF, the Alabama Department of Public Health conducts twice the number of standard surveys and applies progressive enforcement until the nursing home either (a) graduates from the SFF program or (b) their provider agreement with Medicare/Medicaid is terminated.

(uuuuu) "Specialized services for MD or ID" - The services specified by the state that exceed the services ordinarily provided by the nursing facility (NF) under its per diem rate. These services must be provided or arranged by the state and could include hiring additional staff or contractors such as qualified mental health/intellectual disability professionals. When specialized services are combined with services provided by the NF, the result is a continuous and aggressive implementation of an individualized plan of care for individuals with MD or ID. The resident's Level II PASARR identifies the specialized services required by the resident.

(vvvvv) "Speech, language or other functional communication systems" - The resident's ability to effectively communicate requests, needs, opinions, and urgent problems; to express

emotion, to listen to others and to participate in social conversation whether in speech, writing, gesture, behavior, or a combination of these (e.g., a communication board or electronic augmentative communication device).

(wwwww) "State Plan" – The Alabama Medicaid Agency State Plan.

(xxxxx) "Student nurse apprentice" - A nursing student who is engaged in a registered apprenticeship, pursuant to the Alabama Industry Recognized and Registered Apprenticeship Program Act and has obtained an Alabama State Board of Nursing issued permit.

(yyyyy) "Supervision/adequate supervision" - An intervention and means of mitigating the risk of an accident. Facilities are obligated to provide adequate supervision to prevent accidents. Adequate supervision is determined by assessing the appropriate level and number of staff required, the competency and training of the staff, and the frequency of supervision needed. This determination is based on the individual resident's assessed needs and identified hazards in the resident environment. Adequate supervision may vary from resident to resident and from time to time for the same resident.

(zzzzz) "Terminally ill" - The individual has a medical prognosis that his or her life expectancy is 6 months or less if the illness runs its normal course. (42 CFR §418.3)

(aaaaaa) "Therapeutic diet" - A diet ordered by a physician or other delegated provider that is part of the treatment for a disease or clinical condition, to eliminate, decrease, or increase certain substances in the diet (e.g., sodium or potassium), or to provide mechanically altered food when indicated.

(bbbbbb) "Therapeutic leave"- Absences for purposes other than required hospitalization.

(cccccc) "Total health status" - Includes functional status, nutritional status, rehabilitation and restorative potential, ability to participate in activities, cognitive status, oral health status, psychosocial status, and sensory and physical impairments.

(dddddd) "Training and Abuse Registry" - The Alabama Department of Public Health shall establish and maintain such registry. The registry shall provide for the inclusion of specific documented findings by the Alabama Department of Public Health of resident neglect, abuse, exploitation, mistreatment, or misappropriation of resident property by any individual used by a nursing facility, as well as any brief statement of the individual disputing the findings. In the case of inquiries to the registry concerning an individual listed in the registry, any information disclosed concerning such a finding shall also include disclosure of any such statement in the registry relating to the finding or a clear and accurate summary of such a statement. Individuals must be notified in writing prior to the inclusion of findings in the registry and allowed the opportunity for a hearing in the event the individual disputes the findings.

1. Nurse Aide Training. The names and addresses of all nurse aides who attended an approved training program and who have successfully passed the approved competency evaluation will be included on the registry. The only exception of the requirement for attendance at an approved training program is those nurses' aides who are hired by a nursing facility prior to July 1, 1989, and who successfully pass the approved competency evaluation prior to January 1, 1990.

(eeeeee) “Transfer and discharge” - Includes movement of a resident to a bed outside of the certified facility whether that bed is in the same physical plant or not. “Transfer and discharge” does not refer to movement of a resident to a bed within the same certified facility. *(*See, 42 CFR §483.5*)*. Specifically, transfer refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility when the resident expects to return to the original facility. Discharge refers to the movement of a resident from a bed in one certified facility to a bed in another certified facility or other location in the community, when return to the original facility is not expected.

(ffffff) “Transfer” – The resident’s ability to move between surfaces to/from: bed, chair, wheelchair, and standing positions. (Excludes to/from bath/toilet.)

(gggggg) “Trauma” - Results from an event, series of events, or set of circumstances that is experienced by an individual

as physically or emotionally harmful or life threatening and that has lasting adverse effects on the individual's functioning and mental, physical, social, emotional, or spiritual well-being.

(hhhhhh) "Trauma-informed care" - An approach to delivering care that involves understanding, recognizing, and responding to the effects of all types of trauma. A trauma-informed approach to care delivery recognizes the widespread impact, and signs and symptoms of trauma in residents, and incorporates knowledge about trauma into care plans, policies, procedures, and practices to avoid re-traumatization. Adapted from: SAMHSA's Concept of Trauma and Guidance for a Trauma-Informed Approach, https://store.samhsa.gov/system/files/sma14-4884.pdf.

(iiiiii) "Treatment" - Medical care, nursing care, and interventions provided to maintain or restore health and well-being, improve functional level, or relieve symptoms.

(jjjjjj) "Teletype (TTY) and Telecommunications Device for the Deaf TDD)" - Acronyms used interchangeably to refer to any type of text-based telecommunications equipment used by a person who does not have enough functional hearing to understand speech, even with amplification.

(kkkkkk) "Tube feeding" - The delivery of nutrients through a feeding tube directly into the stomach, duodenum, or jejunum. It is also referred to as an enteral feeding.

(llllll) "Urinary incontinence" - The involuntary loss or leakage of urine.

(mmmmmm) "Utilization Guidelines" - Provide instructions for when and how to use the RAI. The Utilization Guidelines are also known as the Long-Term Care Facility Resident Assessment Instrument 3.0 User's Manual.

(nnnnnn) "Ventilator assisted individual (VAI)" - Requires mechanical aid for breathing to augment or replace spontaneous ventilatory efforts to achieve medical stability or maintain life.

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Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.
History: Repealed and Replaced: Filed July 19, 1996; effective August 23, 1996. **Amended:** Filed November 18, 1999; effective December 23, 1999. **Amended:** Filed September 18, 2003; effective

October 23, 2003. **Amended:** Filed June 23, 2004; effective July 28, 2004. **Amended:** Filed April 20, 2005; effective May 25, 2005. **Amended:** Filed June 15, 2016; effective July 30, 2016. **Repealed and New Rule:** Published September 30, 2026; effective November 14, 2026.

420-5-10-.02 Licensing and Administrative Procedures.

(1) Legal Authority for Adoption of Regulations. Pursuant to the authority granted by *Code of Ala. 1975*, § 22-21-20 *et seq*. and in accordance with the Alabama Administrative Procedures Act, *Code of Ala. 1975*, § 41-22-1 *et seq*., the State Committee of Public Health does hereby adopt and promulgate rules governing all nursing facilities in Alabama except those exempt by law from licensure.

(2) Types of License. All licenses are issued for the calendar year and shall expire December 31, unless renewed by the owner for the succeeding year.

a) Regular License. A regular license shall be issued by the State Committee of Public Health after the Committee has determined that the nursing facility is in substantial compliance with the rules herein adopted.

b) Probational License. The State Committee of Public Health may, in its discretion and in lieu of license revocation, issue a probational license to a facility when inspection shows that the maintenance and operation of the facility are such that the facility no longer substantially complies with the rules adopted herein. However, the Committee may issue a probational license only after determining that the health and safety of residents are adequately protected despite the non-compliance, and that the facility has submitted an adequate written plan to correct the non-compliance in a timely manner.

(3) Application and Fee.

a) Every facility shall be required to submit an application for license accompanied by the required statutory fee, in accordance with the provisions of § 22-21-24 of the *Code of Alabama (1975)*. Every application must be submitted on a form supplied by the Committee and must contain all the information requested on said form, along with the required fee, in order for the application to be processed and considered.

b) Name of Facility. Every facility shall be designated by a permanent and distinctive name, which shall be used in applying for a license and shall not be changed without prior

written notice to the Committee specifying the name to be discontinued as well as the new name.

(4) Licensing.

a) Issuance of License. The license document issued by the State Committee of Public Health shall set forth the name and location of the facility, the type of facility, and the bed capacity for which the institution is licensed, and the type of license (temporary, regular, or probational).

b) Separate License. A separate license shall be required for each nursing facility when more than one facility is operated under the same management; (separate licenses are not required for separate buildings on the same grounds used by the same facility). Facilities offering different types of healthcare services in one building or complex of buildings (e.g., a building housing a nursing facility and a hospital) shall also be separately licensed.

c) Basis for Denial of License.

1) The State Committee of Public Health may deny a license to any corporation, partnership, or individual making application to own or operate any nursing facility if said corporation, partnership, or individual:

a. Falsified any information or record required by the application or license; or

b. Has been convicted of a felony, in this or any other state or federal jurisdiction, for physical, mental, or verbal abuse or neglect of an individual or misappropriation of property of a nursing facility resident or financial abuse of residents; or

c. Has been convicted of fraud in this or any other state or federal jurisdiction; or

d. Has previously been the subject of license revocation proceedings and does not demonstrate a recent ability and willingness to fully comply with State Committee of Public Health rules; or

e. Does not demonstrate adequate resources, ability, or intent, to fully comply with the State Committee of Public Health rules.

d) Basis for License Revocation. The State Committee of Public Health may revoke a license to operate a nursing facility if the owner and/or operator of said facility:

1) Violates any of the provisions of Code of Alabama(1975) § 22-21-20, *et seq.*, or the rules and regulations issued pursuant thereto;

2)Permits, aides or abets the commission of any illegal act in such facility; or

3) Engages in conduct or practices deemed by the State Committee of Public Health to be detrimental to the welfare of the residents of such facility.

(5) Right of Review. Whenever a license is denied or revoked, the applicant or licensee will be afforded an opportunity for a hearing in accordance with the requirements for contested case proceedings under the Alabama Administrative Procedures Act, § 41-22-1 *et seq.*, *Code of Alabama (1975)*, and Chapter 420-1-3 of the Alabama Administrative Code.

a) In the case of a license revocation, prior notice of the grounds for proposed revocation and the date, time, and place set for the hearing shall be given in accordance with the Alabama Administrative Procedures Act, § 41-22-1, *et seq.*, *Code of Alabama (1975)* and Chapter 420-1-3 of the Alabama Administrative Code (AAC).

b) All due process and procedural protection granted to the licensee or applicant by the Alabama Administrative Procedures Act shall be provided.

c) All appeals from adverse hearing proceedings shall be subject to the requirements of the Alabama Administrative Procedures Act.

(6) Re-issuance of License. The following changes in the status of the facility will require issuance of a new license, upon application and payment of license fee:

(a) Change in Facility Ownership. A change of ownership occurs whenever there is a change in the legal form under which the controlling entity is organized. Transactions constituting a change of ownership include, but are not limited to, the following:

1) Sale or donation of the facility's legal title.

2) Lease of the entire facility's real and personal property.

3) A sole proprietor becomes a member of a partnership or corporation, succeeding him as the new operator.

4) A partnership dissolves.

5) One partnership is replaced by another through the removal, addition or substitution of a partner.

6) A general partnership becomes a limited partnership, or a limited partnership becomes general partnership.

7) Two (2) or more corporations merge and the originally licensed corporation does not survive;

8) Corporations consolidate;

9) A non-profit corporation becomes a general corporation, or a for-profit corporation becomes non-profit.

10) Transfers between levels of government.

(b) Increase in bed capacity.

(c) The following status changes require issuance of a new license without payment of licensure fee:

1) Change in type of care offered (e.g., nursing facility to skilled, distinct part skilled nursing facility changes).

2) Change of location.

3) Change in name of the facility.

(d) The governing body shall file with the State Committee of Public Health an application for license 30 days before any proposed change requiring a new license, in order to permit processing of the application and issuance of the license prior to the desired effective date of the change.

(7) Compliance Exceptions. At its discretion, the State Committee of Public Health may grant an exception to, or modify the application of, one or more provisions of these rules or referenced codes, for a period and under conditions, if any, determined by the Committee. The exceptions or modification shall be based on hardship, impracticability, or economic infeasibility in complying with the rules. The facility's request shall be in writing, shall state the specific provisions for which the exception or modification is requested, and reasons for each requested exception or modification.

(8) Compliance with State and Local Laws.

(a) Licensing of Staff. Staff of the facility shall be currently licensed or registered in accordance with the applicable laws.

(b) Compliance with Other Laws. The facility shall be in compliance with laws relating to fire and safety, sanitation, communicable and reportable diseases, Certificate of Need, and other relevant health and safety requirements.

(9) Inspections. Failure or refusal to submit to a survey will result in initiation of license revocation proceedings. Findings noted during a survey shall be corrected by execution of an acceptable plan of correction. The plan of correction shall be succinctly written to address identified problems in a timely manner and returned to the Alabama Department of Public Health not later than 10 calendar days after receipt of Statement of Deficiencies.

(a) The Alabama Department of Public Health will review the plan of correction and at its discretion may:

1) Request the plan to be revised.

2) Conduct offsite and/or onsite visit to determine the facility's compliance.

(10) Renewal Applications. A renewal application and an annual licensure fee must be submitted to arrive at the Alabama Department of Public Health, not later than December 31 each year to assure continued licensure status.
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Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.
History: Repealed and Replaced: Filed July 19, 1996; effective August 23, 1996. **Amended:** Filed November 18, 1999; effective December 23, 1999. **Amended:** Filed September 18, 2003; effective October 23, 2003. **Repealed and New Rule:** Published September 30, 2026; effective November 14, 2026.

420-5-10-.03 Administrative Management.

(1) A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

(2) A facility must be licensed under applicable state and local law.

(3) The facility must operate and provide services in compliance with all applicable federal, state, and local laws, regulations, and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility. Facilities must meet the applicable provisions of HHS regulations

pertaining to nondiscrimination on the basis of race, color, or national origin; nondiscrimination on the basis of disabilities; nondiscrimination on the basis of age; protection of human subjects of research and fraud and abuse; and protection of individually identifiable health information. Although these regulations are not in themselves considered requirements under this part, their violation may result in the revocation of the facility license and determination of non-compliance.

(4) Governing Body. The facility must have a governing body, or designated persons functioning as a governing body, that is legally responsible for establishing and implementing policies regarding the management and operation of the facility.

(5) The governing body appoints the administrator who is:

(a) Licensed by the state where licensing is required.

(b) Responsible for the management of the facility.

(c) Reports to and is accountable to the governing body.

(6) The governing body is responsible and accountable for the QAPI Program.

(7) A current roster of the governing body members shall be maintained in the nursing facility. At its discretion, the Alabama Department of Public Health may request that a copy of this roster be placed on file with the Nursing Home Division, Health Provider Standards, Alabama Department of Public Health.

(a) The facility must supply full and complete information to the Alabama Department of Public Health as to the identity:

(1) Of each officer and director of the corporation where the nursing facility is organized as a corporation.

(2) Of each partner where a nursing facility is organized as a partnership.

(b) Of each person who has any direct or indirect ownership interest of 10 per centum or more in such nursing facility or who is the owner (in whole or in part) of any mortgage, deed of trust, note, or other obligation secured (in whole or in part) by such nursing facility or any of the property or assets of such nursing facility, and

(c) In case a nursing facility is organized as a corporation, of each officer and director of the corporation, and

(d) In case a nursing facility is organized as a partnership, the name of each partner.

(e) The governing body shall submit to the state agency within 15 days any changes in the information herein required.

(f) There must be an individual authorized in writing to act for the administrator during absences.

(g) Written notification shall be made to the Alabama Department of Public Health, within 15 days of the administrator's appointment.

(h) The accounting method and procedures shall be sufficient to permit an annual audit, accurate determination of the cost of operation, the cost per resident day, and accounting for resident's funds.

(i) Whenever there is found to be evidence of fraud or misrepresentation to secure money or property from residents, or applicants, or there is any evidence of misappropriation or conversion of money or property of residents or applicants, this must be reported to the proper authorities at the Alabama Department of Public Health.

(j) Unusual Occurrences. Occurrences such as catastrophes and unusual occurrences which threaten the welfare, safety, or health of residents, personnel, or visitors shall be documented within 24 hours of the incident or occurrence. This documentation shall be retained in the facility for at least 2 years. All records required by this subsection shall be, upon request, made immediately available to surveyors employed by the Alabama Department of Public Health. Copies of such records shall be forwarded to the Alabama Department of Public Health promptly upon request. The term "unusual occurrences" includes life threatening burns, and deaths under unusual circumstances.

(k) Fires shall be reported within 24 hours of the occurrence to the Technical Services Unit of the Alabama Department of Health.

(8) Staff Qualifications. The facility must employ on a full-time, part-time, or consultant basis those professionals necessary to carry out the provisions of these requirements.

(9) Professional staff must be licensed, certified, or registered in accordance with applicable state laws.

(10) Use of Outside Resources. If the facility does not employ a qualified professional person to furnish a specific service to be provided by the facility, the facility must have that service furnished to residents by a person or agency outside the facility under an arrangement described in Section 1861(w) of the Social

Security Act as amended or an agreement described in paragraph of this section.

(11) Arrangements as described in Section 1861(w) of the Social Security Act as amended or agreements pertaining to services furnished by outside resources must specify in writing that the facility assumes responsibility for:

(a) Obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility.

(b) The timeliness of the services.

(12) Medical Director. The facility must designate a physician to serve as medical director.

(13) The medical director is responsible for:

(a) Implementation of resident care policies.

(b) The coordination of medical care in the facility.

(14) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

(15) If the facility provides its own laboratory services, i.e., bedside testing including glucose or glucometer, the services must meet the applicable condition for coverage of the services furnished by laboratories specified in Part 493 of Title 42 Code of Federal Regulations.

(16) If the facility does not provide laboratory services on site, it must have an agreement to obtain these services only from a laboratory that meets the requirements of Part 493 of Title 42 Code of Federal Regulations.

(17) The facility must:

(a) Provide or obtain laboratory services only when ordered by a physician; physician assistant; or nurse practitioner in accordance with state law, including scope of practice laws.

(b) Promptly notify the ordering physician, physician assistant, or nurse practitioner of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician’s orders.

(c) Assist the resident in making transportation arrangements to and from the source of service if the resident needs assistance.

(d) File in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.

(18) Radiology and Other Diagnostic Services. The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

(19) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals contained in § 482.26 of Title 42 Code of Federal Regulations.

(20) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare.

(21) The facility must:

(a) Provide or obtain radiology and other diagnostic services only when ordered by a physician, physician assistant, or nurse practitioner in accordance with state law, including scope of practice laws.

(b) Promptly notify the ordering physician, physician assistant, or nurse practitioner of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician’s orders.

(c) Assist the resident in making transportation arrangements to and from the source of service, if the resident needs assistance.

(d) File in the resident's clinical record signed and dated reports of radiologic and other diagnostic services.

(22) Clinical Records. The facility must maintain clinical records on each resident in accordance with accepted professional standards and practices that are:

(a) Complete.

(b) Accurately documented.

(c) Readily accessible.

(d) Systematically organized.

(23) Clinical records must be retained for:

(a) Five years from the date of discharge when there is no requirement in state law; or

(b) For a minor, 3 years after a resident reaches legal age under state law.

(24) The facility must safeguard clinical record information against loss, destruction, or unauthorized use.

(25) The facility must keep confidential all information contained in the resident's records, regardless of the form or storage method of the records, except when release is:

(a) For treatment, payment, or healthcare operations, as permitted by and in compliance with 45 CFR § 164.506;

(b) Required by law.

(c) For public health activities, reporting of abuse, neglect, or domestic violence, health oversight activities, judicial and administrative proceedings, law enforcement purposes, organ donation purposes, research purposes, or to coroners, medical examiners, funeral directors, and to avert a serious threat to health or safety as permitted by and in compliance with 45 CFR § 164.512.

(d) To the individual, or their resident representative where permitted by applicable law.

(26) The clinical record must contain:

(a) Sufficient information to identify the resident.

(b) A record of the resident's assessments.

(c) The comprehensive plan of care and services provided.

(d) The results of any pre-admission screening and resident review evaluations and determinations conducted by the state.

(e) Physician, nurse, and other licensed professionals progress notes.

(f) Laboratory, radiology and other diagnostic services reports as required under 420-5-10-.16.

(27) Disaster and Emergency Preparedness. The facility must have detailed written plans and procedures to meet all potential emergencies and disasters, such as fire, severe weather, and missing residents.

(a) The facility must train all employees in emergency procedures when they begin to work in the facility.

(b) Periodically review the procedures with existing staff.

(c) Carry out unannounced staff drills using those procedures.

(28) In accordance with Section 1861(l) of the Social Security Act, the facility (other than a nursing facility which is located in a state on an Indian reservation) must have in effect a written transfer agreement with one or more hospitals approved for participation under the Medicare and Medicaid programs that reasonably assures that:

(a) Residents will be transferred from the facility to the hospital and ensured of timely admission to the hospital when transfer is medically appropriate, as determined by the attending physician or, in an emergency situation, by another practitioner in accordance with facility policy and consistent with state law.

(b) Medical and other information needed for care and treatment of residents, and when the transferring facility deems it appropriate, for determining whether such residents can receive appropriate services or receive services in a less restrictive setting than either the facility or the hospital, or be reintegrated into the community will be exchanged between the providers.

(29) The facility is considered to have a transfer agreement in effect if the facility has attempted in good faith to enter into an agreement with a hospital sufficiently close to the facility to make transfer feasible.

(30) Disclosure of Ownership. The facility must comply with the Disclosure requirements of §§ 420.206 and 455.104 of Title 42 Code of Federal Regulations.

(31) The facility must provide written notice to the Alabama Department of Public Health, if a change occurs in:

(a) Persons with an ownership or control interest;

(b) The officers, directors, agents, or managing employees;

(c) The corporation, association, or other company responsible for the management of the facility; or

(d) The facility's administrator or director of nursing.

(32) The notice specified in paragraph (31) of this section must include the identity of each new individual or company.

(33) Facility Closure-Administrator.

(a) Any individual who is the administrator of the facility must submit to Alabama Department of Public Health, Bureau of Health Provider Standards, the State LTC Ombudsman, residents of the facility, and the legal representatives of such residents or other responsible parties, written notification of an impending closure:

1) At least 60 days prior to the date of closure; or

2) In the case of a facility where the federal secretary for Health and Human Services or a state terminates the facility's participation in the Medicare and/or Medicaid programs, not later than the date that the secretary determines appropriate.

(b) Any individual who is the administrator of the facility must ensure that the facility does not admit any new residents on or after the date on which such written notification is submitted; and

1) Include in the notice the plan, that has been approved by the state, for the transfer and adequate relocation of the residents of the facility by a date that would be specified by the state prior to closure, including assurances that the residents would be transferred to the most appropriate facility or other setting in terms of quality, services, and location, taking into consideration the needs, choice, and best interests of each resident.

(34) Facility Closure. The facility must have in place policies and procedures to ensure that the administrator's duties and responsibilities involve providing the appropriate notices in the event of a facility closure.

(a) The administrators must provide timely written notice to the state survey agency, the State LTC Ombudsman, residents of the facility, and the legal representatives of residents or other responsible parties, including the CMS Regional Office (RO), the State Medicaid Agency, and staff responsible for providing care and services to residents.

(35) Binding Arbitration Agreements. If a facility chooses to ask a resident or his or her representative to enter into an agreement for binding arbitration, the facility must comply with all of the requirements in this section.

(a) The facility must not require any resident or his or her representative to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at, the facility and must explicitly inform the resident or his or her representative of his or her right not to sign the agreement as a condition of

admission to, or as a requirement to continue to receive care at, the facility.

(b) The facility must ensure that:

1) The agreement is explained to the resident and his or her representative in a form and manner that he or she understands, including in a language the resident and his or her representative understands.

2) The resident or his or her representative acknowledges that he or she understands the agreement.

(c) The agreement must explicitly grant the resident or his or her representative the right to rescind the agreement within 30 calendar days of signing the agreement.

(d) The agreement must explicitly state that neither the resident nor his or her representative is required to sign an agreement for binding arbitration as a condition of admission to, or as a requirement to continue to receive care at the facility.

(e) The agreement may not contain any language that prohibits or discourages the resident or anyone else from communicating with federal, state, or local officials, including but not limited to, federal and state surveyors, other federal or state health department employees, and representative of the Office of the State Long-Term Care Ombudsman, in accordance with 420-5-10-.05 (Resident’s Rights).

(f) The agreement provides for the selection of a neutral arbitrator agreed upon by both parties.

(g) The agreement provides for the selection of a venue that is convenient to both parties.

(h) When the facility and a resident resolve a dispute through arbitration, a copy of the signed agreement for binding arbitration and the arbitrator's final decision must be retained by the facility for 5 years after the resolution of that dispute and be available for inspection upon request by CMS or its designee.

(36) Hospice Services.

(a) A long-term care (LTC) facility may do either of the following:

1) Arrange for the provision of hospice services through an agreement with one or more Medicare-certified hospices.

2) Not arrange for the provision of hospice services at the facility through an agreement with a Medicare-certified hospice and assist the resident in transferring to a facility that will arrange for the provision of hospice services when a resident requests a transfer.

(b) If hospice care is furnished in an LTC facility through an agreement as specified in this section with a hospice, the LTC facility must meet the following requirements:

1) Ensure that the hospice services meet professional standards and principles that apply to individuals providing services in the facility, and to the timeliness of the services.

2) Have a written agreement with the hospice that is signed by an authorized representative of the hospice and an authorized representative of the LTC facility before hospice care is furnished to any resident. The written agreement must set out at least the following:

a. The services the hospice will provide.

b. The hospice's responsibilities for determining the appropriate hospice plan of care.

c. The services the LTC facility will continue to provide based on each resident's plan of care.

d. A communication process, including how communication will be documented between the LTC facility and the hospice provider, to ensure that the needs of the resident are addressed and met 24 hours per day.

e. A provision that the LTC facility immediately notifies the hospice about the following:

(i) A significant change in the resident's physical, mental, social, or emotional status.

(ii) Clinical complications that suggest a need to alter the plan of care.

(iii) A need to transfer the resident from the facility for any condition.

(iv) The resident's death.

f. A provision stating that the hospice assumes responsibility for determining the appropriate

course of hospice care, including the determination to change the level of services provided.

g. An agreement that it is the LTC facility's responsibility to furnish 24-hour room and board care, meet the resident's personal care and nursing needs in coordination with the hospice representative, and ensure that the level of care provided is appropriately based on the individual resident's needs.

h. A delineation of the hospice's responsibilities, including but not limited to, providing medical direction and management of the patient; nursing; counseling (including spiritual, dietary, and bereavement); social work; providing medical supplies, durable medical equipment, and drugs necessary for the palliation of pain and symptoms associated with the terminal illness and related conditions; and all other hospice services that are necessary for the care of the resident's terminal illness and related conditions.

i. A provision that when the LTC facility personnel are responsible for the administration of prescribed therapies, including those therapies determined appropriate by the hospice and delineated in the hospice plan of care, the LTC facility personnel may administer the therapies where permitted by state law and as specified by the LTC facility.

j. A provision stating that the LTC facility must report all alleged violations involving mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property by hospice personnel, to the hospice administrator immediately when the LTC facility becomes aware of the alleged violation.

k. A delineation of the responsibilities of the hospice and the LTC facility to provide bereavement services to LTC facility staff.

3) Each LTC facility arranging for the provision of hospice care under a written agreement must designate a member of the facility's interdisciplinary team who is responsible for working with hospice representatives to coordinate care to the resident provided by the LTC facility staff and hospice staff. The interdisciplinary team member must have a clinical background, function within their state scope of practice act, and have the

ability to assess the resident or have access to someone that has the skills and capabilities to assess the resident.

The designated interdisciplinary team member is responsible for the following:

a. Collaborating with hospice representatives and coordinating LTC facility staff participation in the hospice care planning process for those residents receiving these services.

b. Communicating with hospice representatives and other healthcare providers participating in the provision of care for the terminal illness, related conditions, and other conditions, to ensure quality of care for the patient and family.

c. Ensuring that the LTC facility communicates with the hospice medical director, the patient's attending physician, and other practitioners participating in the provision of care to the patient as needed to coordinate the hospice care with the medical care provided by other physicians.

d. Obtaining the following information from the hospice:

(i) The most recent hospice plan of care specific to each patient.

(ii) Hospice election form.

(iii) Physician certification and recertification of the terminal illness specific to each patient.

(iv) Names and contact information for hospice personnel involved in hospice care of each patient.

(v) Instructions on how to access the hospice's 24-hour on-call system.

(vi) Hospice medication information specific to each patient.

(vii) Hospice physician and attending physician (if any) orders specific to each patient.

(viii) Ensuring that the LTC facility staff provides orientation in the policies and

procedures of the facility, including patient rights, appropriate forms, and record keeping requirements, to hospice staff furnishing care to LTC residents.

4) Each LTC facility providing hospice care under a written agreement must ensure that each resident's written plan of care includes both the most recent hospice plan of care and a description of the services furnished by the LTC facility to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being, as required at 420-5-10-.10 (Quality of Life).

(37) Social Worker. Any facility with more than 120 beds must employ a qualified social worker on a full-time basis. A qualified social worker is:

(a) An individual with a minimum of a bachelor's degree in social work or a bachelor's degree in a human services field including, but not limited to, sociology, gerontology, special education, rehabilitation counseling, and psychology.

(b) One year of supervised social work experience in a healthcare setting working directly with individuals.

(38) Facility Assessment.

(a) The facility must conduct and document a facility wide assessment to determine what resources are necessary to care for its residents competently during both day-to-day operations and emergencies. The facility must review and update that assessment, as necessary, and at least annually. The facility must also review and update this assessment whenever there is, or the facility plans for, any change that would require a substantial modification to any part of this assessment. The facility assessment must address or include:

1) The facility’s resident population, including, but not limited to:

a. Both the number of residents and the facility’s resident capacity.

b. The care required by the resident population considering the types of diseases, conditions, physical and cognitive disabilities, overall acuity, and other pertinent facts that are present within that population.

c. The staff competencies and skill set that are necessary to provide the level and types of care needed for the resident population.

d. The physical environment, equipment, services, and other physical plant considerations that are necessary to care for this population.

e. Any ethnic, cultural, or religious factors that may potentially affect the care provided by the facility, including, but not limited to, activities and food and nutrition services.

2) The facility's resources, including but not limited to:

a. All buildings and/or other physical structures and vehicles.

b. Equipment (medical and non-medical).

c. Services provided, such as physical therapy, pharmacy, and specific rehabilitation therapies.

d. All personnel, including managers, staff (both employees and those who provide services under contract), and volunteers, as well as their education and/or training and any competencies related to resident care.

e. Contracts, memorandums of understanding, or other agreements with third parties to provide services or equipment to the facility during both normal operations and emergencies.

f. Health information technology resources, such as systems for electronically managing patient records and electronically sharing information with other organizations.

(b) A facility-based and community-based risk assessment, utilizing an all-hazards approach.

Author: Rick Harris, Walter T. Geary, Jr. M.D., Amber Clark-Brown, M.D., Nancy L. Eady.
Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.
History: Repealed and Replaced: Filed July 19, 1996; effective August 23, 1996. **Amended:** Filed November 18, 1999; effective December 23, 1999. **Amended:** Filed September 18, 2003; effective October 23, 2003. **Amended:** Filed June 23, 2004; effective July 28, 2004. **Amended:** Filed June 15, 2016; effective July 30, 2016. **Repealed and New Rule:** Published September 30, 2026; effective November 14, 2026.

420-5-10-.04 Personnel.

(1) General. The administrator shall be responsible for implementation and maintenance of written personnel policies and procedures that support sound resident care and personnel practices. Personnel records shall be in effect current and available for each employee and contain sufficient information to support placement in the position to which assigned. Written policies for control of communicable disease shall be in effect to ensure that employees with symptoms or signs of communicable disease or infected skin lesions are not permitted to work, and a safe and sanitary environment for personnel exists. Incidents and accidents to personnel shall be reviewed to identify health and safety hazards.

(2) Personnel Records. Each nursing facility shall maintain a personnel record for each employee. As a minimum, the record shall include:

(a) Application for employment which contains information regarding education, training, experience, and if applicable, registration, and/or licensure information of the applicant.

(b) A job description.

(c) General administrative and job-related orientation.

(d) A background check for criminal history and verification that the employee does not appear on the Alabama Nurse Aide Abuse Registry or the Alabama Elderly and Adult in Need of Protective Services Abuse Registry.

(3) In addition to requirements at 420-5-10-.21 (Infection Control), each facility shall:

(a) Establish vaccination requirements for employees that are consistent with current recommendations from the Centers for Disease Control and Prevention (CDC) and the federal Occupational Safety and Health Administration (OSHA).

(b) Ensure personnel absent from duty because of any communicable disease shall not return to duty until examined by a physician or freedom from any condition that might endanger the health of residents or employees. Documentation of freedom from communicable disease shall be available in facility records.

(4) Personnel Qualifications, Requirements, and Training.

(a) Qualifications of Personnel. The name and qualifications of all professional employees shall be kept on file for inspection by the State Committee of Public Health.

(b) Staff Development. Each employee shall receive appropriate orientation to the facility and its policies and to his/her position and job duties to ensure competency in the job placement. All employees shall participate in in-service educational programs planned and conducted for the development and improvement of their skills.

(5) Nurse Aides. As a general rule, a facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless:

(a) That individual is competent to provide nursing related services.

(b) That individual has completed a training and competency evaluation program; or

(c) That individual has been deemed or determined competent by the Alabama Certified Nurse Aide Registry.

(6) A facility must not use any individuals working in the facility whose name appears on the Alabama Nurse Aide Abuse Registry or the Alabama Elderly and Adult in Need of Protective Services Abuse Registry.

(7) Non-permanent Employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee, any individual who does not meet the requirements in paragraphs 5(b) & 5(c) above as a nurse aide.

(8) Minimum Competency. A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual:

(a) Is a full-time employee in a state-approved training and competency evaluation program;

(b) Has demonstrated competence through satisfactory participation in a state-approved nurse aide training and competency evaluation program; or

(c) Has been deemed or determined competent by the Alabama Certified Nurse Aide Registry.

(9) Registry Verification. Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless:

(a) The individual is a full-time employee in a training and competency evaluation program approved by the state; or

(b) The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the state and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.

(10) Multi-state Registry Verification. Before allowing an individual to serve as a nurse aide, a facility must contact the Alabama Certified Nurse Aide Registry to seek information from every state registry the facility believes includes information on the individual.

(11) Required Retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing related services for monetary compensation, the individual must complete a new training and competency evaluation program.

(12) Regular In-service Education. The facility must complete a performance review of every nurse aide at least once every 12 months and must provide regular in-service education based on the outcome of these reviews. The in-service training must:

(a) Be sufficient to ensure the continuing competence of nurse aides, but must be no less than 12 hours per year.

(b) Address areas of weakness as determined in nurse aides' performance reviews and may address the special needs of residents as determined by the facility staff.

(c) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

(13) Proficiency of Nurse Aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.
Author: Patricia E. Ivie, Dr. Amber Clark-Brown, Felicia Williams-Smith, Lee Brannon, Lisa Flowers, Donna Milstead, Nancy L. Eady
Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.
History: Repealed and Replaced: Filed July 19, 1996; effective August 23, 1996. **Repealed and New Rule:** Published September 30, 2026; effective November 14, 2026.

420-5-10-.05 Resident Rights.

(1) Resident Rights. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility, which include those specified in this section.

(2) The facility must treat each resident with dignity and respect and care for each resident in a manner and in an environment that promotes maintenance or enhancement of his or her quality of life, recognizing each resident's individuality. The facility must protect and promote the rights of the residents.

(3) A facility must provide equal access to quality care regardless of diagnosis, severity of condition, or payment source. A facility must establish and maintain identical policies and practices regarding transfer, discharge, and the provision of services under the state plan for all residents regardless of payment source.

(4) Exercise of Rights. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

(5) The facility must ensure that the resident can exercise his or her rights without interference, coercion, discrimination, or reprisal from the facility.

(6) The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights and to be supported by the facility in the exercise of his or her rights.

(7) In the case of a resident who has not been adjudged incompetent by the state court, the resident has the right to designate a representative, in accordance with state law and any legal surrogate so designated may exercise the resident's rights to the extent provided by state law. The same-sex spouse of a resident must be afforded treatment equal to that afforded to an opposite-sex spouse if the marriage was valid in the jurisdiction in which it was celebrated.

(a) The resident representative has the right to exercise the resident's rights to the extent those rights are delegated to the representative.

(b) The resident retains the right to exercise those rights not delegated to a resident representative, including the right to revoke a delegation of rights, except as limited by state law.

(8) The facility must treat the decisions of a resident representative as the decisions of the resident to the extent required by the court or delegated by the resident, in accordance with applicable law.

(9) The facility shall not extend the resident representative the right to make decisions on behalf of the resident beyond the extent required by the court or delegated by the resident, in accordance with applicable law.

(10) If the facility has reason to believe that a resident representative is making decisions or taking actions that are not in the best interests of a resident, the facility shall report such concerns when and, in the manner, required under state law.

(11) In the case of a resident adjudged incompetent under the laws of a state by a court of competent jurisdiction, the rights of the resident devolve to and are exercised by the resident representative appointed under state law to act on the resident's behalf. The court-appointed resident representative exercises the resident's rights to the extent judged necessary by a court of competent jurisdiction, in accordance with state law.

(a) In the case of a resident representative whose decision-making authority is limited by state law or court appointment, the resident retains the right to make those decisions outside the representative's authority.

(b) The resident's wishes and preferences must be considered in the exercise of rights by the representative.

(c) To the extent practicable, the resident must be provided with opportunities to participate in the care planning process.

(12) Planning and Implementing Care. The resident has the right to be informed of, and participate in, his or her treatment, including:

(a) The right to be fully informed in language that he or she can understand his or her total health status, including but not limited to, his or her medical condition.

(b) The right to be informed, in advance, of the care to be furnished and the type of care giver or professional that will furnish care.

(c) The right to be informed in advance, by the physician or other practitioner or professional, of the risks and benefits of proposed care, of treatment and treatment alternatives or treatment options and to choose the alternative or option he or she prefers.

(13) The right to participate in the development and implementation of his or her person-centered plan of care, including but not limited to:

(a) The right to participate in the planning process, including the right to identify individuals or roles to be included in the planning process, the right to request meetings, and the right to request revisions to the person-centered plan of care.

(b) The right to participate in establishing the expected goals and outcomes of care, the type, amount, frequency, and duration of care, and any other factors related to the effectiveness of the plan of care.

(c) The right to be informed in advance of changes to the plan of care.

(d) The right to receive the services and/or items included in the plan of care.

(e) The right to see the care plan, including the right to sign after significant changes to the plan of care.

(14) The facility shall inform the resident of the right to participate in his or her treatment and shall support the resident in this right. The planning process must:

(a) Facilitate the inclusion of the resident and/or resident representative.

(b) Include an assessment of the residents' strengths and needs.

(c) Incorporate the residents' personal and cultural preferences in developing goals of care.

(15) The right to self-administer medications if the interdisciplinary team has determined that this practice is clinically appropriate.

(16) Choice of Attending Physician. The resident has the right to choose his or her attending physician.

(a) The physician must be licensed to practice.

(b) If the physician chosen by the resident refuses to or does not meet requirements specified in this part, the facility may seek alternate physician participation to assure provision of appropriate and adequate care and treatment.

(c) The facility must ensure that each resident remains informed of the name, specialty, and way of contacting the physician and other primary care professionals responsible for his or her care.

(d) The facility must inform the resident if the facility determines that the physician chosen by the resident is unable or unwilling to meet requirements specified in this part and the facility seeks alternate physician participation to ensure provision of appropriate and adequate care and treatment. The facility must discuss the alternative physician participation with the resident and honor the resident's preferences, if any, among options.

(e) If the resident subsequently selects another attending physician who meets the requirements specified in this part, the facility must honor that choice.

(17) Respect and Dignity. The resident has a right to be treated with respect and dignity, including: The right to retain and use personal possessions, including furnishings, and clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

(18) The right to reside and receive services in a facility with reasonable accommodation of resident needs and preferences except when to do so would endanger the health or safety of the resident or other residents.

(19) The right to share a room with his or her spouse when married residents live in the same facility and both spouses' consent to the arrangement.

(20) The right to share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents' consent to the arrangement.

(21) The right to receive written notice, including the reason for the change, before the resident's room or roommate in the facility is changed.

(22) The right to refuse to transfer to another room in the facility, if the purpose of the transfer is:

(a) To relocate a resident of a skilled nursing facility (SNF) from the distinct part of the institution that is an SNF to a part of the institution that is not an SNF, or

(b) To relocate a resident of a NF from the distinct part of the institution that is a NF to a distinct part of the institution that is an SNF.

(c) Solely for the convenience of staff.

(23) A resident's exercise of the right to refuse transfer does not affect the resident's eligibility or entitlement to Medicare or Medicaid benefits.

(24) Self-determination. The resident has the right to, and the facility must promote and facilitate resident self-determination through support of resident choice, including but not limited to the rights specified in this section.

(a) The resident has a right to choose activities, schedules (including sleeping and waking times), healthcare and providers of healthcare services consistent with his or her interests, assessments, and plan of care and other applicable provisions of this part.

(b) The resident has a right to make choices about aspects of his or her life in the facility that are significant to the resident.

(c) The resident has a right to interact with members of the community and participate in community activities both inside and outside the facility.

(d) The resident has a right to participate in other activities, including social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(25) The facility must provide immediate access to any resident by:

(a) Any representative of the federal Secretary of Health and Human Services.

(b) Any representative of the state.

(c) Any representative of the office of the state long term care ombudsman, (established under Section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. § 3001 *et seq.).*

(d) The resident's individual physician.

(e) Any representative of the protection and advocacy systems, as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. § 15001 *et seq.).*

(f) Any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder (established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. § 10801, *et seq.).*

(g) The resident representative.

(26) The resident has a right to receive visitors of his or her choosing at the time of his or her choosing, subject to the resident's right to deny visitation when applicable, and in a manner that does not impose on the rights of another resident.

(a) The facility must provide immediate access to a resident by immediate family and other relatives of the resident, subject to the resident's right to deny or withdraw consent at any time.

(b) The facility must provide immediate access to a resident by others who are visiting with the consent of the resident, subject to reasonable clinical and safety restrictions and the resident's right to deny or withdraw consent at any time.

(c) The facility must provide reasonable access to a resident by any entity or individual that provides health, social, legal, or other services to the resident, subject to the resident's right to deny or withdraw consent at any time.

(d) The facility must have written policies and procedures regarding the visitation rights of residents, including those setting forth any clinically necessary or reasonable restriction or limitation or safety restriction or limitation, when such limitations may apply consistent with the requirements of this subpart, that the facility may need to place on such rights and the reasons for the clinical or safety restriction or limitation.

(27) A facility must meet the following requirements:

(a) Inform each resident (or resident representative, where appropriate) of his or her visitation rights and related facility policy and procedures, including any clinical or safety restriction or limitation on such rights, consistent with the requirements of this subpart, the reasons for the restriction or limitation, and to whom the restrictions apply, when he or she is informed of his or her other rights under this section.

(b) Inform each resident of the right, subject to his or her consent, to receive the visitors whom he or she designates including, but not limited to, a spouse (including a same-sex spouse), a domestic partner (including a same-sex domestic partner), another family member, or a friend, and his or her right to withdraw or deny such consent at any time.

(c) Not restrict, limit, or otherwise deny visitation privileges based on race, color, national origin, religion, sex, gender identity, sexual orientation, or disability.

(d) Ensure that all visitors enjoy full and equal visitation privileges consistent with resident preferences.

(28) The resident has a right to organize and participate in resident groups in the facility.

(a) The facility must provide a resident or family group, if one exists, with private space; and take reasonable steps, with the approval of the group, to make residents and family members aware of upcoming meetings in a timely manner.

(b) Staff, visitors, or other guests may attend resident group or family group meetings only at the respective group's invitation.

(c) The facility must provide a designated staff person who is approved by the resident or family group and the facility

and who is responsible for providing assistance and responding to written requests that result from group meetings.

(d) The facility must consider the views of a resident or family group and act promptly upon the grievances and recommendations of such groups concerning issues of resident care and life in the facility.

1) The facility must be able to demonstrate their response and rationale for such response.

2) This should not be construed to mean that the facility must implement as recommended every request of the resident or family group.

(e) The resident has a right to participate in family groups.

(f) The resident has a right to have family member(s) or other resident representative(s) meet in the facility with the families or resident representative(s) of other residents in the facility.

(29) The resident has a right to choose or refuse to perform services for the facility and the facility must not require a resident to perform services for the facility. The resident may perform services for the facility, if he or she chooses, when:

(a) The facility has documented the resident’s need or desire for work in the plan of care.

(b) The plan specifies the nature of the services performed and whether the services are voluntary or paid.

(c) Compensation for paid services is at or above prevailing rates.

(d) The resident agrees to the work arrangement described in the plan of care.

(30) The resident has a right to manage his or her financial affairs. This includes the right to know, in advance, what charges a facility may impose against a resident's personal funds.

(a) The facility must not require residents to deposit their personal funds with the facility. If a resident chooses to deposit personal funds with the facility, upon written authorization of a resident, the facility must act as a

fiduciary of the resident's funds and hold, safeguard, manage, and account for the personal funds of the resident deposited with the facility, as specified in this section.

(b) Deposit of Funds.

1) In General. Except as set out in paragraph (B) below of this section, the facility must deposit any residents' personal funds in excess of $100 in an interest-bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain a resident's personal funds that do not exceed $100 in a non-interest bearing account, interest-bearing account, or petty cash fund.

2) Residents whose care is funded by Medicaid: The facility must deposit the resident’s personal funds in excess of $50 in an interest-bearing account (or accounts) that is separate from any of the facility's operating accounts, and that credits all interest earned on resident's funds to that account. (In pooled accounts, there must be a separate accounting for each resident's share.) The facility must maintain personal funds that do not exceed $50 in a non-interest bearing account, interest-bearing account, or petty cash fund.

(31) Accounting and Records.

(a) The facility must establish and maintain a system that assures a full and complete and separate accounting, according to generally accepted accounting principles, of each resident’s personal funds entrusted to the facility on the resident’s behalf.

(b) The system must preclude any commingling of resident funds with facility funds or with the funds of any person other than another resident.

(c) The individual financial record must be available to the resident through quarterly statements and upon request.

(32) Notice of Personal Funds.

(a) Notice of Certain Balances. The facility must notify each resident that receives Medicaid benefits:

1) When the amount in the resident's account reaches $200 less than the SSI resource limit for one person, specified in Section 1611(a)(3)(B) of the Social Security Act.

2) That, if the amount in the account, in addition to the value of the resident's other nonexempt resources, reaches the SSI resource limit for one person, the resident may lose eligibility for Medicaid or SSI.

(b) Conveyance Upon Discharge, Eviction, or Death. Upon the discharge, eviction, or death of a resident with a personal fund deposited with the facility, the facility must convey within 30 days the resident's funds, and a final accounting of those funds, to the resident, or in the case of death, the individual or probate jurisdiction administering the resident's estate, in accordance with state law.

(33) Assurance of Financial Security. The facility must purchase a surety bond or otherwise provide assurance satisfactory to the secretary of the federal Department of Health and Human Services, to assure the security of all personal funds of residents deposited with the facility.

(34) The facility must not impose a charge against the personal funds of a resident for any item or service for which payment is made under Medicaid or Medicare (except for applicable deductible and coinsurance amounts).

(35) The facility may charge the resident for requested services that are more expensive than or more than covered services in accordance with 42 CFR § 489.32. (This does not affect the prohibition on facility charges for items and services for which Medicaid has paid. See, 42 CFR § 447.15, which limits participation in the Medicaid program to providers who accept, as payment in full, Medicaid payment plus any deductible, coinsurance, or copayment required by the plan to be paid by the individual.)

(a) Services Included in Medicare or Medicaid payment. During a covered Medicare or Medicaid stay, facilities must not charge a resident for the following categories of items and services:

1) Nursing services.

2) Food and nutrition services.

3) An activity program.

4) Room/bed maintenance services.

5) Routine personal hygiene items and services as required to meet the needs of residents, including, but not limited to, hair hygiene supplies, comb, brush, bath soap, disinfecting soaps, or specialized cleansing agents when indicated to treat special skin problems or to fight infection, razor, shaving cream, toothbrush, toothpaste, denture adhesive, denture cleaner, dental floss, moisturizing lotion, tissues, cotton balls, cotton swabs, deodorant, incontinence care and supplies, sanitary napkins and related supplies, towels, washcloths, hospital gowns, over the counter drugs, hair and nail hygiene services, bathing assistance, and basic personal laundry.

6) Medically related social services.

7) Hospice services elected by the resident and paid for under the Medicare Hospice Benefit or paid for by Medicaid under a state plan.

(b) Items and Services that may be Charged to Residents' Funds. Paragraphs of this section are general categories and examples of items and services that the facility may charge to residents' funds if they are requested by a resident, if they are not required to achieve the goals stated in the resident's care plan, if the facility informs the resident that there will be a charge, and if payment is not made by Medicare or Medicaid:

1) Telephone, including a cellular phone.

2) Television/radio, personal computer, or other electronic device for personal use.

3) Personal comfort items, including smoking materials, notions and novelties, and confections.

4) Cosmetic and grooming items and services more than those for which payment is made under Medicaid or Medicare.

5) Personal clothing.

6) Personal reading matter.

7) Gifts purchased on behalf of a resident.

8) Flowers and plants.

9) Cost to participate in social events and entertainment outside the scope of the activities program.

10) Non-covered special care services such as privately hired nurses or aides.

11) Private room, except when therapeutically required (for example, isolation for infection control).

12) Except as provided below in this section, specially prepared or alternative food requested instead of the food and meals generally prepared by the facility.

13) The facility may not charge for special foods and meals, including medically prescribed dietary supplements, ordered by the resident's physician, physician assistant or nurse practitioner.

14) When preparing food and meals, a facility must take into consideration residents' needs and preferences and the overall cultural and religious make-up of the facility's population.

(a) Requests for Items and Services.

1. The facility can only charge a resident for any non-covered item or service if such item or service is specifically requested by the resident.

(b) The facility must not require a resident to request any item or service as a condition of admission or continued stay.

(c) The facility must inform, orally and in writing, the resident requesting an item or service for which a charge will be made that there will be a charge for the item or service and what the charge will be.

(36) Information and Communication. The resident has the right to be informed of his or her rights and of all rules and regulations

governing resident conduct and responsibilities during his or her stay in the facility.

(37) The facility must provide a notice of rights and services to the resident prior to or upon admission and during the resident's stay.

(a) The facility must inform the resident both orally and in writing in a language that the resident understands his or her rights and all rules and regulations governing resident conduct and responsibilities during the stay in the facility.

(b) The facility must also provide the resident with the state developed notice of Medicaid rights and obligations, if any.

(c) Receipt of such information, and any amendments to it, must be acknowledged in writing.

(38) The resident has the right to access personal and medical records pertaining to him or herself.

(a) The facility must provide the resident with access to personal and medical records pertaining to him or herself, upon an oral or written request, in the form and format requested by the individual, if it is readily producible in such form and format (including in an electronic form or format when such records are maintained electronically), or, if not, in a readable hard copy form or such other form and format as agreed to by the facility and the individual, within 24 hours (excluding weekends and holidays).

(b) The facility must allow the resident to obtain a copy of the records or any portions thereof including in an electronic form or format when such records are maintained electronically) upon request and 2 working days advance notice to the facility. The facility may impose a reasonable, cost-based fee on the provision of copies, provided that the fee includes only the cost of:

1) Labor for copying the records requested by the individual, whether in paper or electronic form.

2) Supplies for creating the paper copy or electronic media if the individual requests that the electronic copy be provided on portable media.

3) Postage when the individual has requested the copy be mailed.

(39) With the exception of information described in paragraphs 47 and 66 of this section, the facility must ensure that information is provided to each resident in a form and manner the resident can access and understand, including in an alternative format or in a language that the resident can understand. Summaries that translate information described in this section may be made available to the patient at their request and expense in accordance with applicable law.

(40) The resident has the right to receive notices orally (meaning spoken) and in writing (including Braille) in a format and a language he or she understands, including:

(a) Required notices as specified in this section. The facility must furnish to each resident a written description of legal rights which includes:

1) A description of the manner of protecting personal funds, under paragraph 39 of this section.

2) A description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment of resources under Section 1924(c)of the Social Security Act.

3) A list of names, addresses (mailing and email), and telephone numbers of all pertinent state regulatory and informational agencies, resident advocacy groups such as the State Survey Agency, the State Licensure Office, the State Long-Term Care Ombudsman Program, the protection and advocacy agency, adult protective services where state law provides for jurisdiction in long-term care facilities, the local contact agency for information about returning to the community, and the Medicaid Fraud Control Unit.

4) A statement that the resident may file a complaint with the state Survey Agency concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives' requirements, and requests for information regarding returning to the community.

(b) Information and contact information for state and local advocacy organizations including but not limited to the State Survey Agency, the State Long-Term Care Ombudsman Program (established under Section 712 of the Older Americans Act of 1965, as amended 2016 (42 U.S.C. § 3001, *et seq*.) and the protection and advocacy system (as designated by the state, and as established under the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. § 15001, *et seq*.)

(c) Information regarding Medicare and Medicaid eligibility and coverage.

(d) Contact information for the Aging and Disability Resource Center (established under Section 202(a)(20)(B)(iii) of the Older Americans Act), or other No Wrong Door Program.

(e) Contact information for the Medicaid Fraud Control Unit.

(f) Information and contact information for filing grievances or complaints concerning any suspected violation of state or federal nursing facility regulations, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, non-compliance with the advance directives' requirements, and requests for information regarding returning to the community.

(41) The facility must post, in a form and manner accessible and understandable to residents and/or resident representatives:

(a) A list of names, addresses (mailing and email), and telephone numbers of all pertinent state agencies and advocacy groups, such as the State Survey Agency, the State Licensure Office, adult protective services where state law provides for jurisdiction in long-term care facilities, the Office of the State Long-Term Care Ombudsman Program, the protection and advocacy network, home and community-based service programs, and the Medicaid Fraud Control Unit.

(b) A statement that the resident may file a complaint with the state Survey Agency concerning any suspected violation of state or federal nursing facility regulation, including but not limited to resident abuse, neglect, exploitation, misappropriation of resident property in the facility, and non-compliance with the advanced directives requirements (42

CFR part 489 subpart I) and requests for information regarding returning to the community.

(42) The resident has the right to have reasonable access to the use of a telephone, including TTY and TDD services, and a place in the facility where calls can be made without being overheard. This includes the right to retain and use a cellular phone at the resident's own expense.

(43) The facility must protect and facilitate the resident's right to communicate with individuals and entities within and external to the facility, including reasonable access to:

(a) A telephone, including TTY and TDD services.

(b) The internet, to the extent available to the facility.

(c) Stationery, postage, writing implements and the ability to send mail.

(44) The resident has the right to send and receive mail, and to receive letters, packages and other materials delivered to the facility for the resident through a means other than a postal service, including the right to:

(a) Privacy of such communications consistent with this section.

(b) Access to stationery, postage, and writing implements at the resident's own expense.

(45) The resident has the right to have reasonable access to and privacy in their use of electronic communications such as email and video communications and for internet research.

(a) If the access is available to the facility.

(b) At the resident's expense, if any additional expense is incurred by the facility to provide such access to the resident.

(c) Such use must comply with state and federal law.

(46) The resident has the right to:

(a) Examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility.

(b) Receive information from agencies acting as client advocates and be afforded the opportunity to contact these agencies.

(47) The facility must:

(a) Post in a place readily accessible to residents, and family members and legal representatives of residents, the results of the most recent survey of the facility.

(b) Have reports with respect to any surveys, certifications, and complaint investigations made respecting the facility during the 3 preceding years, and any plan of correction in effect with respect to the facility, available for any individual to review upon request.

(c) Post notice of the availability of such reports in areas of the facility that are prominent and accessible to the public.

(d) The facility shall not make available identifying information about complainants or residents.

(48) The right to request, refuse, and/or discontinue treatment, to participate in or refuse to participate in experimental research, and to formulate an advance directive. Nothing in this paragraph should be construed as the right of the resident to receive the provision of medical treatment or medical services deemed medically unnecessary or inappropriate.

(49) Advanced Directives. The facility must comply with the following requirements:

(a) These requirements include provisions to inform and provide written information to all adult residents concerning the right to accept or refuse medical or surgical treatment and, at the resident's option, formulate an advance directive.

(b) This includes a written description of the facility's policies to implement advance directives and applicable state law.

(c) Facilities are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met.

(d) If an adult individual is incapacitated at the time of admission and is unable to receive information or articulate whether he or she has executed an advance directive, the facility may give advance directive information to the individual's resident representative in accordance with state law.

(e) The facility is not relieved of its obligation to provide this information to the individual once he or she is able to receive such information. Follow-up procedures must be in place to provide the information to the individual directly at the appropriate time.

(50) The facility must display in the facility written information, and provide to residents and applicants for admission, oral and written information about how to apply for and use Medicare and Medicaid benefits, and how to receive refunds for previous payments covered by such benefits.

(51) Notification of Changes.

(a) A facility must immediately inform the resident; consult with the resident's physician; and notify, consistent with his or her authority, the resident representative(s) when there is:

1) An accident involving the resident which results in injury and has the potential for requiring physician intervention.

2) A significant change in the resident's physical, mental, or psychosocial status (that is, a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications).

3) A need to alter treatment significantly (that is, a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or

4) A decision to transfer or discharge the resident from the facility.

(b) When making notification under paragraph (51)(a) of this section, the facility must ensure that all pertinent information is available and provided upon request to the physician.

(c) The facility must also promptly notify the resident and the resident representative, if any, when there is:

1) A change in room or roommate assignment, or

2) A change in resident rights under federal or state law or regulations.

(d) The facility must record and periodically update the address (mailing and email) and phone number of the resident representative(s).

(52) Admission to a Composite Distinct Part. A facility that is a composite distinct part (as defined in 42 CFR § 483.5) must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations.

(53) The facility must:

(a) Inform each Medicaid-eligible resident, in writing, at the time of admission to the nursing facility and when the resident becomes eligible for Medicaid of:

1) The items and services that are included in nursing facility services under the state plan and for which the resident may not be charged.

2) Those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services.

(b) Inform each Medicaid-eligible resident when changes are made to the items and services.

(54) The facility must inform each resident before, or at the time of admission, and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate.

(a) Where changes in coverage are made to items and services covered by Medicare and/or by the Medicaid State Plan, the facility must provide notice to residents of the change as soon as is reasonably possible.

(b) Where changes are made to charges for other items and services that the facility offers, the facility must inform the resident in writing at least 60 days prior to implementation of the change.

(c) If a resident dies or is hospitalized or is transferred and does not return to the facility, the facility must refund to the resident, resident representative, or estate, as applicable, any deposit or charges already paid, less the facility's per diem rate, for the days the resident actually resided or reserved or retained a bed in the facility, regardless of any minimum stay or discharge notice requirements.

(d) The facility must refund to the resident or resident representative all refunds due the resident within 30 days from the resident's date of discharge from the facility.

(e) The terms of an admission contract by or on behalf of an individual seeking admission to the facility must not conflict with the requirements of these regulations.

(55) Privacy and Confidentiality. The resident has a right to personal privacy and confidentiality of his or her personal and medical records.

(56) Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups, but this does not require the facility to provide a private room for each resident.

(57) The facility must respect the residents right to personal privacy, including the right to privacy in his or her oral (that is, spoken), written, and electronic communications, including the right to send and promptly receive unopened mail and other letters, packages and other materials delivered to the facility for the resident, including those delivered through a means other than a postal service.

(58) The resident has a right to secure and confidential personal and medical records.

(a) The resident has the right to refuse the release of personal and medical records except as specified by applicable federal or state laws.

(b) The facility must allow representatives of the Office of the State Long-Term Care Ombudsman to examine a resident's

medical, social, and administrative records in accordance with state law.

(59) Safe Environment. The resident has a right to a safe, clean, comfortable, and homelike environment, including but not limited to receiving treatment and support for daily living safely.

(60) The facility must provide a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible.

(a) This includes ensuring that the resident can receive care and services safely and that the physical layout of the facility maximizes resident independence and does not pose a safety risk.

(b) The facility shall exercise reasonable care for the protection of the resident's property from loss or theft.

(61) The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior.

(62) The facility must provide clean bed and bath linens that are in good condition.

(63) The facility must provide private closet space in each resident room.

(64) The facility must provide comfortable and safe temperature levels. Facilities initially certified after October 1, 1990, must maintain a temperature range of 71 to 81°F.

(65) The facility must provide for the maintenance of comfortable sound levels.

(66) Grievances.

(a) The resident has the right to voice grievances to the facility or other agency or entity that hears grievances without discrimination or reprisal and without fear of discrimination or reprisal. Such grievances include those with respect to care and treatment which has been furnished as well as that which has not been furnished, the behavior of staff and of other residents, and other concerns regarding their LTC facility stay.

(b) The resident has the right to, and the facility must make, prompt efforts by the facility to resolve grievances the resident may have, in accordance with this paragraph.

(c) The facility must make information on how to file a grievance or complaint available to the resident.

(d) The facility must establish a grievance policy to ensure the prompt resolution of all grievances regarding the residents' rights contained in this paragraph. Upon request, the provider must give a copy of the grievance policy to the resident. The grievance policy must include:

1) Notifying resident individually or through postings in prominent locations throughout the facility of the right to file grievances orally (meaning spoken) or in writing; the right to file grievances anonymously; the contact information of the grievance official with whom a grievance can be filed, that is, his or her name, business address (mailing and email) and business phone number; a reasonable expected time frame for completing the review of the grievance; the right to obtain a written decision regarding his or her grievance; and the contact information of independent entities with whom grievances may be filed, that is, the pertinent state agency, quality improvement organization, State Survey Agency and State Long-Term Care Ombudsman Program or protection and advocacy system.

2) Identifying a grievance official who is responsible for overseeing the grievance process, receiving and tracking grievances through to their conclusions; leading any necessary investigations by the facility; maintaining the confidentiality of all information associated with grievances, for example, the identity of the resident for those grievances submitted anonymously, issuing written grievance decisions to the resident; and coordinating with state and federal agencies as necessary in light of specific allegations.

3) As necessary, taking immediate action to prevent further potential violations of any resident rights while the alleged violation is being investigated.

4) Consistent with 42 CFR §483.12(c)(1), immediately reporting all alleged violations involving neglect, abuse, including injuries of unknown source, and/or

misappropriation of resident property, by anyone furnishing services on behalf of the provider, to the administrator of the provider; and as required by state law.

5) Ensuring that all written grievance decisions include the date the grievance was received, a summary statement of the resident's grievance, the steps taken to investigate the grievance, a summary of the pertinent findings or conclusions regarding the resident's concerns(s), a statement as to whether the grievance was confirmed or not confirmed, any corrective action taken or to be taken by the facility as a result of the grievance, and the date the written decision was issued.

6) Taking appropriate corrective action in accordance with state law if the alleged violation of the residents' rights is confirmed by the facility or if an outside entity having jurisdiction, such as the State Survey Agency, quality improvement organization, or local law enforcement agency confirms a violation for any of these residents' rights within its area of responsibility.

7) Maintaining evidence demonstrating the result of all grievances for a period of no less than 3 years from the issuance of the grievance decision.

(67) Contact with External Entities. A facility must not prohibit or in any way discourage a resident from communicating with federal, state, or local officials, including, but not limited to, federal and state surveyors, other federal or state health department employees, including representatives of the Office of the State Long-Term Care Ombudsman and any representative of the agency responsible for the protection and advocacy system for individuals with mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act of 2000 (42 U.S.C. et seq.), regarding any matter, whether or not subject to arbitration or any other type of judicial or regulatory action.
Author: Patricia E. Ivie, Amber Clark-Brown, M.D., Nancy L. Eady
Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.
History: Repealed and Replaced: Filed July 19, 1996; effective August 23, 1996. **Repealed and New Rule:** Published September 30, 2026; effective November 14, 2026.

420-5-10-.06 **Freedom from Abuse, Neglect, Misappropriation, and Exploitation.**

(1) The resident has the right to be free from abuse, neglect, and freedom from corporal punishment. The facility must not use verbal abuse, physical abuse, mental abuse, sexual abuse, or corporal punishment.

(2) The resident has the right to be free from misappropriation of resident property, and exploitation as defined in this subpart.

(3) The resident has the right to be free from involuntary seclusion.

(4) Restraints. The resident has the right to be free from, and the facility must ensure that the resident is free from, any physical or chemical restraints imposed for purposes of discipline or convenience and not required to treat the resident's medical symptoms. When the use of restraints is indicated, the facility must use the least restrictive alternative for the least amount of time and document ongoing re-evaluation of the need for restraints.

(5) The facility must conduct a background check for criminal history for all employees and healthcare providers, licensure verification for healthcare providers, and review the Department of Human Resources' Adult in Need of Protective Services Abuse Registry for all employees including contract staff who have direct contact with residents upon hire and at least every five years thereafter to ensure the facility not employ or otherwise engage individuals who:

(a) Have been found guilty of abuse, neglect, exploitation, misappropriation of property, or mistreatment by a court of law.

(b) Have had a finding entered in the state Nurse Aide Abuse Registry concerning abuse, neglect, exploitation, mistreatment of residents or misappropriation of their property; or

(c) Have a disciplinary action in effect against his or her professional license by a state licensure body because of a finding of abuse, neglect, exploitation, mistreatment of residents, or misappropriation of resident property.

(6) Report to the State Nurse Aide Registry or licensing authorities any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff.

(7) The facility must ensure that all alleged violations involving exploitation or mistreatment, neglect, or abuse, including injuries unknown source and misappropriation of resident property are reported immediately but not later than 2 hours after the allegation is made, if the events that cause the allegation involve abuse or result in serious bodily injury, or not later than 24 hours if the events that cause the allegation do not involve abuse and do not result in serious bodily injury, to the administrator of the facility and to other officials in accordance with state law through established procedures (including to the State Survey and Certification Agency and adult protective services). The facility must have evidence that all alleged violations are thoroughly investigated.

(a) The facility must prevent further potential abuse, neglect, exploitation, or mistreatment while the investigation is in progress.

(b) The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with state law (including to the State Survey and Certification Agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken. The facility must include a summary of the investigation and evidence that the allegation was investigated thoroughly to the state agency. Evidence of a thorough investigation includes but is not limited to pertinent documentation of interviews with staff or residents, policies, and/or medical records collected or reviewed during the facility's investigation or referenced in the facility's summary of investigation.

(8) The facility must develop and implement written policies and procedures that:

(a) Prohibit and prevent abuse, neglect, and exploitation of residents and misappropriation of resident property.

(b) Establish policies and procedures to investigate any such allegations.

(c) Include training.

(d) Establish coordination with the QAPI Program.

(e) Ensure reporting of crimes occurring in federally funded long-term care facilities in accordance with Section 1150B of the Social Security Act. The policies and procedures must include but are not limited to the following elements:

1) Posting a conspicuous notice of employee rights.

2) Prohibiting and preventing retaliation.

(9) The facility must develop and implement written policies and procedures that ensure reporting of crimes occurring in federally funded long-term care facilities in accordance with Section 1150B of the Social Security Act. The policies and procedures must include but are not limited to the following elements.

(a) Annually notifying covered individuals of that individual's obligation to comply with the following reporting requirements.

1) Each covered individual shall report to the state agency and one or more law enforcement entities for the political subdivision in which the facility is located any reasonable suspicion of a crime against any individual who is a resident of, or is receiving care from, the facility.

2) Each covered individual shall report immediately, but not later than 2 hours after forming the suspicion, if the events that cause the suspicion result in serious bodily injury, or not later than 24 hours if the events that cause the suspicion do not result in serious bodily injury.

Author: Patricia E. Ivie, Nancy L. Eady
Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.
History: Repealed and Replaced: Filed July 19, 1996; effective August 23, 1996. **Amended:** Filed July 20, 1998; effective August 25, 1998. **Amended:** Filed June 23, 2004; effective July 28, 2004. **Repealed and New Rule:** Published September 30, 2026; effective November 14, 2026.

420-5-10-.07 Admission, Transfer, and Discharge.

(1) The facility must establish and implement an admissions policy.

(2) The facility must:

(a) Not request or require residents or potential residents to waive their rights as set forth in this subpart and in applicable state, federal or local licensing or certification laws, including but not limited to their rights to Medicare or Medicaid.

(b) Not request or require oral or written assurance that residents or potential residents are not eligible for, or will not apply for, Medicare or Medicaid benefits.

(c) Not request or require residents or potential residents to waive potential facility liability for losses of personal property.

(d) Ensure the facility must have physician orders for the resident's immediate care at time of admission to the facility.

(3) The facility must not request or require a third-party guarantee of payment to the facility as a condition of admission or expedited admission or continued stay in the facility. However, the facility may request and require a resident representative who has legal access to a resident's income or resources available to pay for facility care to sign a contract, without incurring personal financial liability, to provide facility payment from the resident's income or resources.

(4) In the case of a person eligible for Medicaid, a nursing facility must not charge, solicit, accept, or receive, in addition to any amount otherwise required to be paid under the state plan, any gift, money, donation, or other consideration as a precondition of admission, expedited admission, or continued stay in the facility.

(a) A nursing facility may charge a resident who is eligible for Medicaid for items and services the resident has requested and received, and that are not specified in the state plan as included in the term "nursing facility services" so long as the facility gives proper notice of the availability and cost of these services to residents and does not condition the resident's admission or continued stay on the request for and receipt of such additional services.

(b) A nursing facility may solicit, accept, or receive a charitable, religious, or philanthropic contribution from an organization or from a person unrelated to a Medicaid eligible resident or potential resident, but only to the extent that the contribution is not a condition of admission, expedited admission, or continued stay in the facility for a Medicaid eligible resident.

(5) States or political subdivisions may apply stricter admissions standards under state or local laws than are specified in this section, to prohibit discrimination against individuals entitled to Medicaid.

(6) A nursing facility must disclose and provide to a resident or potential resident prior to time of admission, notice of special characteristics or service limitations of the facility.

(7) A nursing facility that is a composite distinct part must disclose in its admission agreement its physical configuration, including the various locations that comprise the composite distinct part, and must specify the policies that apply to room changes between its different locations.

(8) Equal Access to Quality Care.

(a) A facility must establish, maintain and implement identical provision of services for all individuals regardless of source of payment.

(b) The facility may charge any amount for services furnished to non-Medicaid residents unless otherwise limited by state law and consistent with the notice requirement describing the charges.

(c) The state is not required to offer additional services on behalf of a resident other than services provided in the state plan.

(d) Room changes in a composite distinct part. Room changes in a facility that is a composite distinct part are subject to the requirements of 420-5-10-.04 and must be limited to moves within the building in which the resident resides, unless the resident voluntarily agrees to move to another of the composite distinct part’s locations.

(9) Transfer and Discharge Requirements.

(a) The facility must permit each resident to remain in the facility, and not transfer or discharge the resident from the facility unless:

1) The transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility.

2) The transfer or discharge is appropriate because the resident's health has improved sufficiently so the resident no longer needs the services provided by the facility.

3) The safety of individuals in the facility is endangered due to the clinical or behavioral status of the resident.

4) The health of individuals in the facility would otherwise be endangered.

5) The resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility. Nonpayment applies if the resident does not submit necessary paperwork for the third-party payment or after the third party, including Medicare and Medicaid, denies the claim and the resident refuses to pay for his or her stay. For a resident who becomes eligible for Medicaid after admission to a nursing facility, the nursing facility may charge a resident only allowable charges under Medicaid; or

6) The facility ceases to operate.

(b) The facility may not transfer or discharge the resident while the appeal is pending, when a resident exercises his or her right to appeal a transfer or discharge notice from the facility, unless the failure to discharge or transfer would endanger the health or safety of the resident or other individuals in the facility. The facility must document the danger that failure to transfer or discharge would pose.

(c) Documentation. When the facility transfers or discharges a resident under any of the circumstances specified in this section, the facility must ensure that the transfer and discharge is documented in the resident's medical record and appropriate information is communicated to the receiving healthcare institution or provider.

1) Documentation in the resident's medical record must include:

a. The basis for the transfer.

b. The specific resident need(s) that cannot be met, facility attempts to meet the resident needs, and the service available at the receiving facility to meet the need(s).

2) The documentation must be made by:

a. The resident's physician when transfer or discharge is necessary.

b. A physician when transfer or discharge is necessary.

(d) Information provided to the receiving provider must include a minimum of the following:

1) Contact information of the practitioner responsible for the care of the resident.

2) Resident representative information including contact information.

3) Advance Directive information.

4) All special instructions or precautions for ongoing care, as appropriate.

5) Comprehensive care plan goals.

6) All other necessary information, including a copy of the resident’s discharge summary, and any other documentation, as applicable, to ensure a safe and effective transition of care.

(10) Notice Before Transfer.

(a) Before a facility transfers or discharges a resident, the facility must:

1) Notify the resident and the resident’s representative(s) of the transfer or discharge and the reasons for the move in writing and in a language and manner they understand. The facility must send a copy of the notice to a representative of the Office of the State Long-Term Care Ombudsman.

2) Record the reasons for the transfer or discharge in the resident's medical record.

3) Include in the notice the items described in this section.

(b) Timing of the notice.

1) Except when specified in this section, the notice of transfer or discharge required under this section must be made by the facility at least 30 days before the resident is transferred or discharged.

2) Notice may be made as soon as practicable before transfer or discharge when:

a. The safety of individuals in the facility would be endangered.

b. The health of individuals in the facility would be endangered.

c. The resident's health improves sufficiently to allow a more immediate transfer or discharge.

d. An immediate transfer or discharge is required by the resident's urgent medical needs, or

e. A resident has not resided in the facility for 30 days.

(c) Contents of the notice.

1) The written notice must include the following:

a. The reason for transfer or discharge.

b. The effective date of transfer or discharge.

c. The location to which the resident is transferred or discharged.

d. A statement of the resident’s appeal rights, including the name, address (mailing and email), and telephone number of the entity which receives such requests; and information on how to obtain an appeal form and assistance in completing the form and submitting the appeal hearing request.

e. The name, address (mail and email), and telephone number of the State Long Term Care Ombudsman.

f. For nursing facility residents with intellectual and developmental disabilities, or related disabilities, the mailing address and telephone

number of the Alabama Developmental Disabilities Advocacy Program (ADDAP) at the University of Alabama School of Law.

g. For nursing facility residents with a mental disorder or related disabilities, the mailing and email address and telephone number of the agency responsible for the protection and advocacy of individuals with a mental disorder established under the Protection and Advocacy for Mentally Ill Individuals Act.

(d) Changes to the Notice. If the information in the notice changes prior to affecting the transfer or discharge, the facility must update the recipients of the notice as soon as practicable once the updated information becomes available.

(e) Notice in Advance of Facility Closure. In the case of facility closure, the individual who is the administrator of the facility must provide written notification prior to the impending closure to the state Survey Agency, the Office of the State Long-Term Care Ombudsman, residents of the facility, and the resident representatives, as well as the plan for the transfer and adequate relocation of the residents.

(11) Orientation for Transfer or Discharge. A facility must provide sufficient preparation and orientation to residents to ensure safe and orderly transfer or discharge from the facility. This orientation must be provided in a form or manner that the resident can understand.

(12) Notice of Bed-hold Policy and Return.

(a) Notice Before Transfer. Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic leave, the nursing facility must provide written information to the resident and a family member or legal representative that specifies:

1) The duration of the bed-hold policy under the state plan, if any, during which the resident is permitted to return and resume residence in the nursing facility.

2) The reserve bed payment policy in the state plan, if any.

3) The nursing facility's policies regarding bed-hold periods, which must be consistent with paragraph (2)(c) of this section, permitting a resident to return.

4) The information specified in this section.

(b) Bed-hold Notice Upon Transfer. At the time of a transfer of resident for hospitalization or therapeutic leave, a nursing facility must provide to the resident and the resident representative written notice which specifies the duration of the bed hold policy.

(13) Permitting Residents to Return to Facility.

(a) A facility must establish and follow a written policy permitting residents to return to the facility after they are hospitalized or placed on therapeutic leave. The policy must provide for the following:

1) A resident whose hospitalization or therapeutic leave exceeds the bed-hold period under the state plan, returns to the facility to their previous room if available or immediately upon the first availability of a bed in a semi-private room, if the resident:

a) Requires the services provided by the facility.

b) Is eligible for Medicare skilled nursing facility services or Medicaid nursing facility services.

2) If the facility determines that a resident who was transferred with an expectation of returning to the facility, cannot return to the facility, the facility must comply with the requirements as they apply to discharges.

(b) Readmission to a Composite Distinct Part. When the facility to which a resident returns is a composite distinct part, the resident must be permitted to return to an available bed in the location of the composite distinct part in which he or she resided previously. If a bed is not available in that location at the time of return, the resident must be given the option to return to that location upon the first availability of a bed there.

Author: Rick Harris, Nancy L. Eady
Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.

History: Repealed and Replaced: Filed July 19, 1996; effective August 23, 1996. **Repealed and New Rule:** Published September 30, 2026; effective November 14, 2026.

420-5-10-.08 Resident Assessment.

(1) Resident Assessment. The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity.

(2) Admission Orders. At the time each resident is admitted, the facility must have physician orders for the resident's immediate care.

(3) Comprehensive Assessments. The facility must make a comprehensive assessment of a resident's needs, strengths, goals, life history, and references, using the resident assessment instrument (RAI) specified by the state. The comprehensive assessment must include at least the following information.

(a) Identification and demographic information.

(b) Customary routine.

(c) Cognitive patterns.

(d) Communication.

(e) Vision.

(f) Mood and behavior patterns.

(g) Psychological well-being.

(h) Physical functioning and structural problems.

(i) Continence.

(j) Disease diagnosis and health conditions.

(k) Dental and nutritional status.

(l) Skin conditions.

(m) Activity pursuit.

(n) Medications.

(o) Special treatments and procedures.

(p) Discharge planning.

(q) Documentation of summary information regarding the additional assessment performed on the care areas triggered by the completion of the Minimum Data Set (MDS).

(r) Documentation of Participation in Assessment. The assessment process must include direct observation and communication with the resident, as well as communication with licensed and non-licensed direct care staff members on all shifts.

(4) Frequency. Assessments must be conducted:

(a) Within 14 calendar days after admission, excluding readmissions in which there is no significant change in the resident's physical or mental condition. (For purposes of this section, "readmission" means a return to the facility following a temporary absence for hospitalization or therapeutic leave.)

(b) Not less than once every 12 months.

(c) Within 14 days after the facility determines, or should have determined, that there has been a significant change in the resident's physical or mental condition. (For purpose of this section, a "significant change" means a major decline or improvement in the resident's status that will not normally resolve itself without further intervention by staff or by implementing standard disease-related clinical interventions, that has an impact on more than one area of the resident's health status and requires interdisciplinary review or revision of the care plan, or both.)

(5) Quarterly Review Assessment. A facility must assess a resident using the quarterly review instrument specified by the state not less frequently than once every 3 months.

(6) A facility must maintain all resident assessments completed within the previous 15 months in the resident's active record and use the results of the assessments to develop, review and revise the resident's comprehensive care plan.

(7) Coordination. A registered nurse must conduct or coordinate each assessment with the appropriate participation of health professionals.

(8) A registered nurse must sign and certify that the assessment is completed. Each individual who completes a portion of the assessment must sign and certify the accuracy of that portion of the assessment.

(a) Penalty for Falsification. An individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement in a resident

assessment is subject to civil money penalties, as specified by the Enforcement Regulations for SNFs and NFs as published in the Federal Register on November 10, 1994, and became effective on July 1, 1995.

(b) Use of Independent Assessors. If a state determines, under a survey or otherwise, that there has been a knowing and willful certification of false statements under paragraph 8(a) of this section, the state may require (for a period specified by the state) that resident assessments under this paragraph be conducted and certified by individuals who are independent of the facility and who are approved by the state.

(c) Under Medicare and Medicaid, an individual who willfully and knowingly:

1) Certifies a material and false statement in a resident assessment is subject to a civil money penalty of not more than $1,000 for each assessment; or

2) Causes another individual to certify a material and false statement in a resident assessment is subject to a civil money penalty or not more than $5,000 for each assessment.

3) Clinical disagreement does not constitute a material and false statement.

(9) Coordination. A facility must coordinate assessments with the Pre-admission Screening and Resident Review (PASARR) Program under Medicaid to the maximum extent practicable to avoid duplicative testing and effort. Coordination includes: Incorporating the recommendations from the PASARR Level II determination and the PASARR evaluation report into a resident's assessment, care planning, and transitions of care.

(10) PASARR

(a) PASARR stands for "preadmission screening for individuals with a mental disorder and individuals with intellectual disability."

(b) A nursing facility must not admit, on or after January 1, 1989, any new residents with a:

1) Mental disorder unless:

a. The State Mental Health Authority has determined, based on an independent physical and mental evaluation performed by a person or entity other than the State Mental Health Authority, prior to admission, that, because of the physical and

mental condition of the individual, the individual requires the level of services provided by a nursing facility.

b. If the individual requires such level of services, whether the individual requires specialized services.

2) Intellectual disability, as defined in this section, unless the State Intellectual Disability or Developmental Disability Authority has determined prior to admission:

a. That, because of the physical and mental condition of the individual, the individual requires the level of services provided by a nursing facility.

b. If the individual requires such level of services, whether the individual requires specialized services for intellectual disability.

(c) Exceptions. For purposes of this section:

1. The preadmission screening program of this section need not provide for determinations in the case of the readmission to a nursing facility of an individual who, after being admitted to the nursing facility, was transferred for care in a hospital.

2. The state may choose not to apply the preadmission screening program to the admission to a nursing facility of an individual:

a. Who is admitted to the facility directly from a hospital after receiving acute inpatient care at the hospital.

b. Who requires nursing facility services for the condition for which the individual received care in the hospital.

c. Whose attending physician has certified, before admission to the facility, that the individual is likely to require less than 30 days of nursing facility services.

(11) A nursing facility must notify the State Mental Health Authority or State Intellectual Disability Authority, as applicable, promptly after a significant change in the mental or physical condition of a resident who has mental illness or intellectual disability for resident review.
Author: Patricia E. Ivie

Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq. **History: Repealed and Replaced:** Filed July 19, 1996; effective August 23, 1996. **Amended:** Filed November 18, 1999; effective December 23, 1999. **Repealed and New Rule:** Published September 30, 2026; effective November 14, 2026.

420-5-10-.09 Comprehensive Person-Centered Care Planning.

(1) Baseline Care Plans. The facility must develop and implement a baseline care plan for each resident that includes the instructions needed to provide effective and person-centered care of the resident that meet professional standards of quality care. The baseline care plan must:

(a) Be developed within 48 hours of a resident's admission.

(b) Include the minimum healthcare information necessary to properly care for a resident including, but not limited to:

1) Initial goals based on admission orders.

2) Physician orders.

3) Dietary orders.

4) Therapy services.

5) Social services.

6) PASARR recommendation, if applicable.

(2) The facility may develop a comprehensive care plan in place of the baseline care plan if the comprehensive care plan is developed within 48 hours of the resident's admission.

(3) The facility must provide the resident and their representative with a summary of the baseline care plan that includes but is not limited to:

(a) The initial goals of the resident.

(b) A summary of the resident's medications and dietary instructions.

(c) Any services and treatments to be administered by the facility and personnel acting on behalf of the facility.

(d) Any updated information based on the details of the comprehensive care plan, as necessary.

(4) Comprehensive Care Plans. The facility must develop and implement a comprehensive person-centered care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, mental, and psychosocial needs that are identified in the comprehensive assessment. The comprehensive care plan must describe the following:

(a) The services that are to be furnished to attain or maintain the resident's highest practicable physical, mental, and psychosocial well-being.

(b) Any services that would otherwise be required but are not provided due to the resident's exercise of rights, including the right to refuse treatment.

(c) Any specialized services or specialized rehabilitative services the nursing facility will provide as a result of PASARR recommendations. If a facility disagrees with the findings of the PASARR, it must indicate its rationale in the resident’s medical record.

(d) In consultation with the resident and the resident’s representative(s):

1) The resident’s goals for admission and desired outcomes.

2) The resident’s preference and potential for future discharge. Facilities must document whether the resident’s desire to return to the community was assessed and any referrals to local contact agencies and/or other appropriate entities, for this purpose.

3) Discharge plans in the comprehensive care plan, as appropriate, in accordance with the requirements set forth in this section.

(e) The service provided or arranged by the facility as outlined by the comprehensive care plan must be culturally competent and trauma informed.

(5) Comprehensive Care Plan must be:

(a) Developed within 7 days after the completion of the comprehensive assessment.

(b) Prepared by an interdisciplinary team, that includes but is not limited to the attending physician, a registered nurse with responsibility for the resident, a nurse aide with responsibility for the resident, a member of the food and nutrition services staff, and to the extent practicable, the participation of the resident and the resident’s representative(s). An explanation must be included in a

resident’s medical record if the participation of the resident or their resident representative is determined not practicable for the development of the resident’s care plan, and other appropriate staff or professionals in disciplines as determined by the resident's needs, or as requested by the resident.

(c) Reviewed and revised by the interdisciplinary team after each assessment, including both the comprehensive and quarterly review assessments.

(6) Services provided or arranged by the facility, as outlined by the comprehensive care plan, must meet professional standards of quality.

(7) Services provided or arranged by the facility, as outlined by the comprehensive care plan, must be provided by qualified persons in accordance with each resident's written plan of care.

(8) Discharge Planning Process. The facility must develop and implement an effective discharge planning process that focuses on the resident’s discharge goals, the preparation of residents to be active partners and effectively transition them to post-discharge care, and the reduction of factors leading to preventable readmissions. The facility’s discharge planning process must be consistent with the discharge rights and:

(a) Ensure that the discharge needs of each resident are identified and result in the development of a discharge plan for each resident.

(b) Include regular re-evaluation of residents to identify changes that require modification of the discharge plan. The discharge plan must be updated, as needed, to reflect these changes.

(c) Involve the interdisciplinary team in the ongoing process of developing the discharge plan.

(d) Consider caregiver/support person availability and the resident’s or caregiver’s/support person(s) capacity and capability to perform required care, as part of the identification of discharge needs.

(e) Involve the resident and resident representative in the development of the discharge plan and inform the resident and resident representative of the final plan.

(f) Address the resident’s goals of care and treatment preferences.

(g) Document that a resident has been asked about their interest in receiving information regarding returning to the community.

1) If the resident indicates an interest in returning to the community, the facility must document any referrals to local contact agencies or other appropriate entities made for this purpose.

2) Facilities must update a resident's comprehensive care plan and discharge plan, as appropriate, in response to information received from referrals to local contact agencies or other appropriate entities.

3) If discharge to the community is determined to not be feasible, the facility must document who made the determination and why.

(h) For residents who are transferred to another SNF or who are discharged to a home health aide (HHA), an inpatient rehabilitation facility (IRF), or a long-term acute care hospital (LTCH), assist residents and their resident representatives in selecting a post-acute care provider by using data that includes, but is not limited to SNF, HHA, IRF, or LTCH standardized patient assessment data, data on quality measures, and data on resource use to the extent the data is available. The facility must ensure that the post-acute care standardized patient assessment data, data on quality measures, and data on resource use is relevant and applicable to the resident's goals of care and treatment preferences.

(i) Document, complete on a timely basis based on the resident's needs, and include in the clinical record, the evaluation of the resident's discharge needs and discharge plan. The results of the evaluation must be discussed with the resident or resident's representative. All relevant resident information must be incorporated into the discharge plan to facilitate its implementation and to avoid unnecessary delays in the resident's discharge or transfer.

(9) Discharge Summary. When the facility anticipates discharge, a resident must have a discharge summary that includes but is not limited to, the following:

(a) A recapitulation of the resident's stay that includes, but is not limited to, diagnoses, course of illness/treatment or therapy, and pertinent lab, radiology, and consultation results.

(b) A final summary of the resident's status to include items in paragraph (4)(a) through (e) of this section, at the time of the discharge that is available for release to authorized

persons and agencies, with the consent of the resident or resident's representative.

(c) Reconciliation of all pre-discharge medications with the resident's post discharge medications both prescribed and over the counter.

(d) A post-discharge plan of care that is developed with the participation of the resident and with the resident's consent, and resident representative(s), which will assist the resident to adjust to his or her new living environment. The post-discharge plan of care must indicate where the individual plans to reside, any arrangements that have been made for the resident's follow-up care and any post-discharge medical and non-medical services.

Author: Patricia E. Ivie, Nancy L. Eady
Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.
History: epealed and Replaced: Filed July 19, 1996; effective August 23, 1996. **Repealed and New Rule:** Published September 30, 2026; effective November 14, 2026.

420-5-10-.10 Quality of Life.

(1) Quality of life is a fundamental principle that applies to all care and services provided to residents. The facility must provide the necessary care and services to each resident in a manner consistent with the resident's comprehensive assessment and plan of care to attain or maintain the highest practicable physical, mental, and psychosocial well-being.

(2) Based on a resident's comprehensive assessment and consistent with the resident's needs and choices, the facility must provide the necessary care and services so that a resident's abilities in activities of daily living do not diminish, unless circumstances of the individual's clinical condition demonstrate a resident's decline of abilities are unavoidable. This includes that:

(a) A resident is given the appropriate treatment and services to maintain or improve his or her ability to carry out the activities of daily living, including:

1) Hygiene - bathing, dressing, grooming, and oral hygiene.

2) Mobility - transfer and ambulation, including walking.

3) Elimination – toileting.

4) Dining - eating, including meals and snacks.

5) Communication - speech, language, and other functional communication systems.

(3) Quality of Life. A facility must care for its residents in a manner and in an environment that promotes maintenance or enhancement of each resident's quality of life.

(a) Dignity. The facility must promote care for residents in a manner and in an environment that maintains or enhances each resident's dignity and respect in full recognition of his or her individuality.

(b) Self-determination and Participation. The resident has the right to:

1) Choose activities, schedules (including sleeping and waking times), healthcare and providers of healthcare services consistent with his or her interests, assessments, and plans of care.

2) Interact with members of the community both inside and outside the facility.

3) Make choices about aspects of his or her life in the facility that are significant to the resident.

(c) Participation in Resident and Family Groups.

1) A resident has the right to organize and participate in resident groups in the facility.

2) A resident's family has the right to meet in the facility with the families of other residents in the facility.

3) The facility must provide a resident or family group, if one exists, with private space.

4) Staff, visitors or other guests may attend meetings at the group's invitation.

5) The facility must provide a designated staff person who is approved by the group and who is responsible for providing assistance and responding to written requests that result from group meetings.

6) When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and life in the facility.

a. The facility must be able to demonstrate their response and rationale for such response.

b. This should not be construed to mean the facility must implement as recommended every request of the group.

(d) Participation in Other Activities. A resident has the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility.

(e) Accommodation of Needs. A resident has the right to:

1) Reside and receive services in the facility with reasonable accommodations of individual needs and preferences, except when the health or safety of the individual or other residents would be endangered.

2) Share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.

3) Share a room with his or her roommate of choice when practicable, when both residents live in the same facility and both residents consent to the arrangement.

4) Receive notice before the resident's room or roommate in the facility is changed.

(f) Activities.

1) The facility must provide, based on the comprehensive assessment and care plan and the preferences of each resident, an ongoing program to support residents in their choice of activities, both facility-sponsored group and individual activities and independent activities, designed to meet the interests of and support the physical, mental, and psychosocial well-being of each resident, encouraging both independence and interaction in the community.

2) The activities program must be directed by a qualified professional who:

a. Is a qualified therapeutic recreation specialist or an activities professional who:

(i) Is registered by the Alabama Department of Public Health.

(ii) Is eligible for certification as a therapeutic recreation specialist or as an

activities professional by a recognized accrediting body on or after October 1, 1990; or

(iii) Has 2 years of experience in a social or recreational program within the last 5 years, one of which was full-time in a resident activities program in a healthcare setting; or

(iv) Is a qualified occupational therapist or occupational therapy assistant; or

(v) Has completed a training course approved by the state.

(g) The program coordinator, if not qualified, must function under the supervision of a consultant to assure the activity program meets needs of residents until the coordinator is qualified.

1) Activities shall be planned at least 1 month in advance.

2) An activity calendar(s) shall be prominently displayed.

3) If a pet therapy program is implemented, the following guidelines must be met:

a. Pets chosen shall be free of contagious disease or sickness (diarrhea, ringworm, etc.). This includes pets residing at the facility.

b. Pets shall be inoculated or vaccinated as required by law, with written verification of current inoculations for pets residing in facilities on file at the facility.

4) Participation records shall be maintained to reflect that activities have been conducted on a group and individual basis and by whom.

5) Participation records for bed-bound/bed-to-chair residents shall reflect the activities conducted, the response to those activities, and who offered activities.

(4) Basic Life Support. Personnel provide basic life support in accordance with professional standards, including CPR, to a resident requiring such emergency care prior to the arrival of emergency medical personnel and subject to related physician orders, the resident’s advance directives, and resident’s code status.

(a) Facilities must have systems in place supported by policies and procedures to ensure there are an adequate number of staff present at all times who are properly trained and/or certified in CPR for Healthcare Providers to be able to provide CPR until emergency medical services arrives.

(b) Each facility must have an Automated External Defibrillator (AED) device available for use and ensure staff have necessary training to properly operate the AED.

(c) If a resident experiences a cardiac or respiratory arrest and the resident does not show obvious clinical signs of irreversible death (e.g. rigor mortis, dependent lividity, decapitation, transection, or decomposition), facility staff must provide basic life support, including CPR, prior to the arrival of emergency medical services, in accordance with the resident's advance directives and any related physician order, such as code status, or in the absence of advance directives or a DNR order.

Author: Patricia E. Ivie, Nancy L. Eady
Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.
History: Repealed and Replaced: Filed July 19, 1996; effective August 23, 1996. **Repealed and New Rule:** Published September 30, 2026; effective November 14, 2026.

420-5-10-.11 Quality of Care.

(1) Quality of care is a fundamental principle that applies to all treatment and care provided to facility residents. Based on the comprehensive assessment of a resident, the facility must ensure that residents receive treatment and care in accordance with professional standards of practice, the comprehensive person-centered care plan, and the residents' choices, including but not limited to the following:

(2) Activities of Daily Living. Based on the comprehensive assessment of a resident, the facility must ensure that:

(a) A resident's abilities in activities of daily living do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable. This includes the resident's ability to:

1) Bathe, dress, and groom.

2) Transfer and ambulate.

3) Toilet.

4) Eat.

5) Use speech, language, or other functional communication systems.

(b) A resident is given the appropriate treatment and services to maintain or improve his or her abilities specified in paragraph (2)(a)above.

(c) A resident who is unable to carry out activities of daily living receives the necessary services to maintain good nutrition, grooming, and personal hygiene.

(3) Vision and hearing. To ensure that residents receive proper treatment and assistive devices to maintain vision and hearing abilities, the facility must, if necessary, assist the resident:

(a) In making appointments, and

(b) By arranging for transportation to and from the office of a practitioner specializing in the treatment of vision or hearing impairment or the office of a professional specializing in the provision of vision or hearing assistive devices.

(4) Skin Integrity. Pressure Ulcers. Based on the comprehensive assessment of a resident, the facility must ensure that:

(a) A resident receives care, consistent with professional standards of practice to prevent pressure ulcers and does not develop pressure ulcers unless the individual's clinical condition demonstrates that they were unavoidable.

(b) A resident with pressure ulcers receives necessary treatment and services, consistent with professional standards of practice, to promote healing, prevent infection, and prevent new ulcers from developing.

(5) Foot Care. To ensure that residents receive proper treatment and care to maintain mobility and good foot health, the facility must:

(a) Provide foot care and treatment, in accordance with professional standards of practice, including to prevent complications from the resident’s medical condition(s); and

(b) If necessary, assist the resident in making appointments with a qualified person, and arranging for transportation to and from such appointments.

(6) Incontinence. Based on the resident's comprehensive assessment, the facility must ensure that:

(a) A resident who is continent of bladder and bowel on admission receives services and assistance to maintain continence unless his or her clinical condition is or becomes such that continence is not possible to maintain.

(b) For a resident with urinary incontinence, based on the resident's comprehensive assessment, the facility must ensure that:

1) A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary.

2) A resident who enters the facility with an indwelling catheter or subsequently receives one is assessed for removal of the catheter as soon as possible unless the resident's clinical condition demonstrates that catheterization is necessary.

3) A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore continence to the extent possible.

(c) For a resident with fecal incontinence, based on the resident's comprehensive assessment, the facility must ensure that a resident who is incontinent of bowel receives appropriate treatment and services to restore as much normal bowel function as possible.

(7) Colostomy, Urostomy, or Ileostomy care. The facility must ensure that residents who require colostomy, urostomy, or ileostomy services receive such care consistent with professional standards of practice, the comprehensive person-centered care plan, and the resident's goals and preferences.

(8) Mobility. Based on the comprehensive assessment of a resident, the facility must ensure that:

(a) A resident who enters the facility without a limited range of motion does not experience reduction in range of motion unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable.

(b) A resident with a limited range of motion receives appropriate treatment and services to increase range of motion and/or to prevent further decrease in range of motion.

(9) Assisted Nutrition and Hydration. (Includes naso-gastric tubes, gastrostomy tubes, both percutaneous endoscopic gastrostomy and percutaneous endoscopic jejunostomy, and enteral fluids). Based on the comprehensive assessment of a resident, the facility must ensure that:

(a) A resident who has been able to eat enough alone or with assistance is not fed by enteral methods unless the resident’s clinical condition demonstrates enteral feeding was clinically indicated and consented to by the resident.

(b) A resident who is fed by an enteral means receives the appropriate treatment and services to restore, if possible, oral eating skills and to prevent complications of enteral feeding including but not limited to prevent aspiration pneumonia, diarrhea, vomiting, dehydration, metabolic abnormalities, and nasal-pharyngeal ulcers.

(10) Parenteral Fluids. Parenteral fluids must be administered consistent with professional standards of practice and in accordance with physician orders, the comprehensive person-centered care plan, and the resident’s goals and preferences.

(11) Respiratory Care, Including Tracheostomy Care and Tracheal Suctioning. The facility must ensure that a resident who needs respiratory care, including tracheostomy care and tracheal suctioning, is provided such care, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents’ goals, and preferences.

(12) Prostheses. The facility must ensure that a resident who has a prosthesis is provided care and assistance, consistent with professional standards of practice, the comprehensive person-centered care plan, the residents’ goals, and preferences, to wear and be able to use the prosthetic device.

(13) Pain Management. The facility must ensure that pain management is provided to residents who require such services,

consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences.

(14) Dialysis. The facility must ensure that residents who require dialysis receive such services, consistent with professional standards of practice, the comprehensive person-centered care plan, and the residents' goals and preferences. Dialysis services can be provided in-house.

(15) Trauma-informed Care. The facility must ensure that residents who are trauma survivors receive culturally competent, trauma-informed care in accordance with professional standards of practice and accounting for residents' experiences and preferences in order to eliminate or mitigate triggers that may cause re-traumatization of the resident.

(16) Accidents. The facility must ensure that:

(a) The resident environment remains as free of accident hazards as is possible.

(b) Each resident receives adequate supervision and assistance devices to prevent accidents.

(17) Nutrition. Based on a resident's comprehensive assessment, the facility must ensure that a resident:

(a) Maintains acceptable parameters of nutritional status, such as body weight or desirable body weight range and electrolyte balance, unless the resident's clinical condition demonstrates that this is not possible, or the resident preferences indicate otherwise.

(b) Receives a therapeutic diet when there is a nutritional problem and the healthcare provider orders a therapeutic diet.

(18) Hydration. The facility must provide each resident with sufficient fluid intake to maintain proper hydration and health.

(19) Bed Rails. The facility must attempt to use appropriate alternatives prior to installing a side or bed rail. If a bed or side rail is used, the facility must ensure correct installation, use, and maintenance of bed rails, including but not limited to the following elements:

(a) Assess the resident for risk of entrapment from bed rails prior to installation.

(b) Review the risks and benefits of bed rails with the resident or resident representative and obtain informed consent prior to installation.

(c) Ensure that the bed's dimensions are appropriate for the resident's size and weight.

(d) Follow the manufacturers' recommendations and specifications for installing and maintaining bed rails.

Author: Patricia E. Ivie, Nancy L. Eady
Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.
History: Repealed and Replaced: Filed July 19, 1996; effective August 23, 1996. **Repealed and New Rule:** Published September 30, 2026; effective November 14, 2026.

420-5-10-.12 Physician Services.

(1) A physician must personally approve in writing a recommendation that an individual be admitted to a facility. Each resident must remain under the care of a physician. A physician, physician assistant, or nurse practitioner must provide orders for the resident's immediate care and needs.

(2) Physician Supervision. The facility must ensure that:

(a) The medical care of each resident is supervised by a physician.

(b) Another physician supervises the medical care of residents when their attending physician is unavailable.

(3) Physician Visits. The physician must:

(a) Review the resident's total program of care, including medications and treatments, at each visit required by paragraph (4)(a) of this section.

(b) Write, sign, and date progress notes at each visit.

(c) Sign and date all orders with the exception of influenza and pneumococcal vaccines, which may be administered per physician-approved facility policy after an assessment for contraindications.

(4) Frequency of Physician Visits.

(a) The resident must be seen by a physician at least once every 30 days for the first 90 days after admission, and at least once every 60 days thereafter.

(b) A physician visit is considered timely if it occurs not later than 10 days after the date the visit was required.

(c) Except as provided in paragraphs (4)(d) of this section, all required physician visits must be made by the physician personally.

(d) At the option of the physician, required visit, may alternate between personal visits by the physician and visits by a physician assistant, or nurse practitioner in accordance with paragraph (5)(a)1, 2, and 3 of this section.

(5) Availability of Physicians for Emergency Care. The facility must provide or arrange for the provision of physician services 24 hours a day, in case of an emergency.

(6) Physician Delegation of Tasks.

(a) Except as specified in paragraph (6)(b) of this section, a physician may delegate tasks to a physician assistant or nurse practitioner who:

1) Agrees to and has signed specific protocols established by the facility and the physician and is on file in the facility.

2) Is acting within the scope of practice as defined by state law.

3) Is under the supervision of the physician.

(b) A physician may not delegate a task when the regulations specify that the physician must perform it personally, or when the delegation is prohibited under state law or by the facility's own policies.

(7) Physician Delegation to Dietitian/Therapist.

(a) A resident’s attending physician may delegate the task of writing dietary orders, consistent with § 483.60, to a qualified dietitian or other clinically qualified nutrition professional who:

1) Is acting within the scope of practice as defined by state law.

2) Is under the supervision of the physician.

(b) A resident's attending physician may delegate the task of writing therapy orders consistent with regulations to a qualified therapist who:

1) Is acting within the scope of practice as defined by state law.

2) Is under the supervision of the physician.

Author: Patricia E. Ivie
Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.
History: Repealed and Replaced: Filed July 19, 1996; effective August 23, 1996. **Amended:** Filed April 20, 2005; effective May 25, 2005. **Amended:** Published March 31, 2022; effective May 15, 2022. **Repealed and New Rule:** Published September 30, 2026; effective November 14, 2026.

420-5-10-.13 Nursing Services.

(1) The facility must have sufficient nursing staff with the appropriate competencies and skill sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment.

(a) Sufficient Staff. The facility must provide services by each of the following types of personnel on a 24-hour basis to provide nursing care to all residents in accordance with resident care plans:

1) Licensed nurses, and other nursing personnel, including but not limited to nurse aides except when waived in this section.

2) The facility must designate a licensed nurse to serve as a charge nurse on each tour of duty except when waived in this section.

(2) The facility must ensure that licensed nurses have the specific competencies and skill sets necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

(a) Providing care includes but is not limited to assessing, evaluating, planning, and implementing resident care plans and responding to resident's needs.

(b) Proficiency of nurse aides. The facility must ensure that nurse aides are able to demonstrate competency in skills and techniques necessary to care for residents' needs, as identified through resident assessments, and described in the plan of care.

(3) Registered Nurse.

(a) The facility must use the services of a registered nurse for at least 8 consecutive hours a day, 7 days a week.

(b) The facility must designate a registered nurse to serve as the director of nursing on a full-time basis.

(c) The director of nursing may serve as a charge nurse only when the facility has an average daily occupancy of 60 or fewer residents.

(4) Required Training of Nursing Aides.

(a) General Rule. A facility must not use any individual working in the facility as a nurse aide for more than 4 months, on a full-time basis, unless:

1) That individual is competent to provide nursing related services.

2) That individual has completed a training and competency evaluation program; or

3) That individual has been deemed or determined competent by the Alabama Certified Nurse Aide Registry.

(b) Non-permanent Employees. A facility must not use on a temporary, per diem, leased, or any basis other than a permanent employee, any individual who does not meet the requirements in paragraphs (a) above or (c) below as a nurse aide.

(c) Competency. A facility must not use any individual who has worked less than 4 months as a nurse aide in that facility unless the individual:

1) Is a full-time employee in a state-approved training and competency evaluation program;

2) Has demonstrated competence through satisfactory participation in a state-approved nurse aide training and competency evaluation program; or

3) Has been deemed or determined competent by the Alabama Nurse Aide Registry.

(5) Registry Verification.

(a) Before allowing an individual to serve as a nurse aide, a facility must receive registry verification that the individual has met competency evaluation requirements unless:

1) The individual is a full-time employee in a training and competency evaluation program approved by the state; or

2) The individual can prove that he or she has recently successfully completed a training and competency evaluation program or competency evaluation program approved by the state and has not yet been included in the registry. Facilities must follow up to ensure that such an individual actually becomes registered.

(b) Multi-state Registry Verification. Before allowing an individual to serve as a nurse aide, a facility must seek information from every state registry established under sections 1819(e)(2)(A) or 1919(e)(2)(A) of the Act that the facility believes will include information on the individual as well as the Department of Human Resources Adult Protective Abuse Registry.

(c) Required Retraining. If, since an individual's most recent completion of a training and competency evaluation program, there has been a continuous period of 24 consecutive months during none of which the individual provided nursing or nursing-related services for monetary compensation, the individual must complete a new training and competency evaluation program or a new competency evaluation program.

(6) Regular In-service Education. The facility must complete a performance review of every nurse aide at least once every 12 months and must provide regular in-service education based on the outcome of these reviews. In-service training must comply with the requirements of 420-5-10-.24.

(7) Nursing Facilities. Waiver of requirement to provide licensed nurses on a 24-hour basis. To the extent that a facility is unable to meet the requirements of paragraphs 3(a) and (b) of this section, a state may waive such requirements with respect to the facility if:

(a) The facility demonstrates to the satisfaction of the state that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities), to recruit appropriate personnel.

(b) The state determines that a waiver of the requirement will not endanger the health or safety of individuals staying in the facility.

(c) The state finds that, for any periods in which licensed nursing services are not available, a registered nurse or a physician is obligated to respond immediately to telephone calls from the facility.

(d) A waiver granted under the conditions listed in paragraph (7)(a) of this section is subject to annual state review.

(e) In granting or renewing a waiver, a facility may be required by the state to use other qualified, licensed personnel.

(f) The state agency granting a waiver of such requirements provides notice of the waiver to the Office of the State Long-Term Care Ombudsman (established under section 712 of the Older Americans Act of 1965) and the protection and advocacy system in the state for individuals with a mental disorder who are eligible for such services as provided by the protection and advocacy agency.

(g) The nursing facility that is granted such a waiver by a state notifies residents of the facility and their resident representatives of the waiver.

(8) SNFs. Waiver of the Requirement to Provide Services of a Registered Nurse for More Than 40 Hours a Week. The secretary of the federal Health and Human Services Agency may waive the requirement that an SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing specified in paragraph (3)(b) of this section, if the secretary finds that:

(a) The facility is located in a rural area and the supply of skilled nursing facility services in the area is not sufficient to meet the needs of individuals residing in the area.

(b) The facility has one full-time registered nurse who is regularly on duty at the facility 40 hours a week.

(c) The facility either:

1) Has only patients whose physicians have indicated (through physicians' orders or admission notes) that they do not require the services of a registered nurse or a physician for a 48-hour period; or

2) Has made arrangements for a registered nurse or a physician to spend time at the facility, as determined necessary by the physician, to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty.

(d) The secretary provides notice of the waiver to the Office of the State Long-Term Care Ombudsman (established under section 712 of the Older Americans Act of 1965) and the protection and advocacy system in the state for individuals with developmental disabilities or mental disorders.

(e) The facility that is granted such a waiver notifies residents of the facility and their resident representatives of the waiver.

(9) Nurse Staffing Information.

(a) Data Requirements. The facility must post the following information daily:

1) Facility name.

2) The current date.

3) The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift:

a. Registered nurses.

b. Licensed practical nurses or licensed vocational nurses (as defined under state law).

c. Certified nurse aides.

d. Resident census.

(b) Posting Requirements. The facility must post the nurse staffing data specified in paragraph (a) of this section daily at the beginning of each shift. Data must be posted as follows:

1) Clear and readable format.

2) In a prominent place readily accessible to residents and visitors.

(c) Public access to posted nurse staffing data. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.

(d) Facility Data Retention Requirements. The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by state law, whichever is greater.

Author: Patricia E. Ivie, Nancy L. Eady
Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.
History: Repealed and Replaced: Filed July 19, 1996; effective August 23, 1996. **Repealed and New Rule:** Published September 30, 2026; effective November 14, 2026.

420-5-10-.14 Behavioral Health.

(1) Each resident must receive, and the facility must provide, the necessary behavioral healthcare and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. Behavioral health encompasses a resident's whole emotional and mental well-being, which includes, but is not limited to, the prevention and treatment of mental and substance use disorders.

(2) The facility must have sufficient staff who provide direct services to residents with the appropriate competencies and skills sets to provide nursing and related services to assure resident safety and attain or maintain the highest practicable physical, mental and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care and considering the number, acuity and diagnoses of the facility's resident population. These competencies and skill sets include,

but are not limited to, knowledge of and appropriate training and supervision for:

(a) Caring for residents with mental and psychosocial disorders, as well as residents with a history of trauma and/or post-traumatic stress disorder, that have been identified in the facility assessment conducted and linked to history of trauma and/or post-traumatic stress disorder.

(b) Implementing non-pharmacological interventions.

(3) Based on the comprehensive assessment of a resident, the facility must ensure that a resident who displays or is diagnosed with mental disorder or psychosocial adjustment difficulty, or who has a history of trauma and/or post-traumatic stress disorder, receives appropriate treatment and services to correct the assessed problem or to attain the highest practicable mental and psychosocial well-being.

(4) A resident who did not originally have a diagnosis of a mental or psychosocial adjustment difficulty or a documented history of trauma and/or post-traumatic stress disorder who begins to display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behaviors, shall be given treatment for the underlying condition. It is not acceptable that the condition continue to deteriorate unless the resident's clinical condition demonstrates that development of such a pattern was unavoidable.

(5) A resident who displays or is diagnosed with dementia receives the appropriate treatment and services to attain or maintain his or her highest practicable physical, mental, and psychosocial well-being.

(6) The facility must provide medically related social services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident.

Author: Patricia E. Ivie, Nancy L. Eady
Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.
History: Repealed and Replaced: Filed July 19, 1996; effective August 23, 1996. **Repealed and New Rule:** Published September 30, 2026; effective November 14, 2026.

420-5-10-.15 Pharmacy Services.

(1) The facility must provide routine and emergency drugs and biologicals to its residents or obtain them under an agreement described in § 483.70(g) of Title 42 Code of Federal Regulations revised 10/01/2019. The facility may permit unlicensed personnel to administer drugs in accordance with §610-X-7-.06 of the Alabama

Committee of Public Nursing Administrative Code, but only under the general supervision of a licensed nurse.

(a) Procedures. A facility must provide pharmaceutical services (including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals) to meet the needs of each resident.

(b) Service Consultation. The facility must employ or obtain the services of a licensed pharmacist who:

1) Provides consultation on all aspects of the provision of pharmacy services in the facility.

2) Establishes a system of records of receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation.

3) Determines that drug records are in order and that an account of all controlled drugs is maintained and periodically reconciled.

(c) Drug Regimen Review.

1) The drug regimen of each resident must be reviewed at least once a month by a licensed pharmacist. The review must include a review of the resident’s medical chart.

2) The pharmacist must report any irregularities to the attending physician and the facility’s medical director and the director of nursing. These reports must be acted upon.

3) Irregularities include, but are not limited to, any drug that meets the criteria set forth in paragraph (d) of this section for an unnecessary drug.

4) Any irregularities noted by the pharmacist during this review must be documented on a separate, written report that is sent to the attending physician and the facility’s medical director and director of nursing and lists, at a minimum, the resident’s name, the relevant drug, and the irregularity the pharmacist identified.

5) The attending physician must document in the resident’s medical record that the identified irregularity has been reviewed and what, if any, action has been taken to address it. If there is to be no change in the medication, the attending physician should document his or her rationale in the resident’s medical record.

6) The facility must develop and maintain policies and procedures for the monthly drug regimen review that include, but are not limited to, time frames for the different steps in the process and steps the pharmacist must take when he or she identifies an irregularity that requires urgent action to protect the resident.

(d) Storage of Drugs and Biologicals.

1) In accordance with state and federal laws, the facility must store all drugs and biologicals in locked compartments under proper temperature controls and permit only authorized personnel to have access to the keys.

2) The facility must provide separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1976 and other drugs subject to abuse, except when the facility uses single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

3) The facility must maintain readily traceable records of receipt and disposition of all controlled drugs.

(e) Destruction of Drugs.

1) The nursing facility develops policies and procedures for the destruction of drugs and biologicals.

2) Controlled substances and legend drugs dispensed to residents, that are unused because the medication is discontinued, or because the resident dies shall be destroyed within 30 days, except unused legend drugs may be donated to a charitable clinic pursuant to Alabama Administrative Code Chapter 420-11-11, et seq.

3) Medications of residents transferred to a hospital may be retained until the resident is returned to the facility. Upon return of the resident to the facility, the physician's order will dictate whether or not the resident is to continue the same drug regimen as previously ordered. Medications not reordered by the physician must be destroyed.

4) Medications ordered to be used on an "as needed" basis shall be destroyed after 90 days if they have

not been used during that period of time. Medications shall be destroyed upon expiration of the drug.

5) Both controlled substances and non-controlled substances may be destroyed on the premises or may be picked up by an environmental agency that provides such service. Drugs to be destroyed shall not be returned to the drug store for destruction.

6) Records must be completed and maintained by the facility that include:

a. Name and address of the facility.

b. Date of destruction/date drugs picked up.

c. Method used in destruction (If picked up by an environmental agency, the record/receipt must indicate the proposed date and method of destruction).

d. Prescription number, name of drug store from which the medicine was dispensed, resident's name, name and strength of drug destroyed, amount destroyed, and reason for destruction.

7) The pharmacist will verify that the list of drugs to be destroyed is accurate and with a registered nurse, will carry out destruction. Both will sign the destruction form indicating amounts listed are correct and have been destroyed. For destruction of controlled substances, there shall be a third witness who may be a law enforcement official, management or supervisory personnel, i.e., administrator, LPN charge nurse, etc. If medications are to be picked up and destroyed by an environmental agency, the registered nurse should verify the list of drugs to be destroyed and should obtain a signed copy of the destruction form as a receipt.

8) If records of destruction are maintained in the resident's medical record, they must be retained for as long as the medical record is kept. If a separate file of destruction records is to be maintained, they must be retained for a period of not less than 2 years.

(f) Labeling of Drugs and Biologicals.

1) All containers of medicines and drugs shall be properly and plainly labeled, including name and strength of drug, resident's name, ordering physician, date of filling, directions for administration, prescription number, expiration date, number of tablets, or capsules sent and any necessary auxiliary

labels. The prescription label shall conform with any additional federal, state, and local requirements.

2) Use of and labeling of generic drugs shall comply with State Board of Pharmacy requirements.

3) When authorized substitution of a drug takes place, there will be established policies and procedures to provide accurate dentification.

4) Over the counter (non-prescription) medicines shall be plainly labeled with the name and strength of the drug. Additional labeling information may be at the discretion of the facility as related in its policies and procedures except that manufacturer's labeling information must be present in the absence of prescription labeling.

5) The contents of all individual prescriptions shall be kept in the original dispensed container bearing the original prescription label.

6) Procedures shall be developed to ensure proper control and labeling for medications provided a resident upon leaving the facility on a temporary absence.

7) Unit dose medications shall be packaged according to an acceptable format to include product name, strength, control number, and expiration date. Procedures for utilization of the system used are developed and approved by administration, nursing, and pharmacy personnel and must comply with federal and state regulations.

(g) Emergency medication kits will be kept in accordance with Alabama Administrative Code Rule 680-X-2 for the Alabama State Board of Pharmacy Rules and Regulations governing institutional pharmacies.

1) Emergency kits may contain controlled substances utilizing the following conditions:

a. The source from which a long-term care facility may obtain controlled substances must be a DEA-registered pharmacy or practitioner.

b. There shall be a maximum 3-day supply of any controlled substance stocked in the emergency kit.

c. The responsibility for proper control and accountability of the emergency kit shall rest with both the nursing facility and the DEA registrant

providing the drug. The facility and the drug provider shall maintain complete and accurate records of the controlled substances placed in the emergency kit including receipt and disposition of the drugs as well as destruction of unused or outdated drugs where appropriate.

d. Adequate security measures shall be provided for the emergency kit (if the controlled drugs are to be maintained within the kit) or the drugs (if they are to be maintained in a separate area) to include double locks. Access to emergency drugs shall be limited to those with an actual need, i.e., medication nurse and/or director of nurses and the pharmacist.

e. Controlled drugs maintained for emergency use may be used only upon the written or telephone orders of the attending physician, who must sign a telephone order as soon as possible after giving it.

f. Violations in these rules and regulations may result in the revocation, denial, or suspension of the privilege of maintaining controlled substance drugs in the emergency kit.

(h) "Stat" Medicine Cabinets

1) Each nursing facility may maintain one "stat" medicine cabinet for the purpose of keeping a minimum amount of stock medications that may be needed quickly or after regular duty hours. If a facility wants more than one "stat" medicine cabinet, it must be approved by the State Committee of Public Health. The following rules apply to such a cabinet:

2) There shall be a minimum number of doses of any medication in the "stat" cabinet based upon the established needs of the facility.

3) There must be a list of contents, approved by the nursing facility, giving the name and strength of the drug and the quantity of each.

4) There shall be records available to show amount received, name of resident and amount used, prescribing physician, time of administration, name of individual removing, and using the medication and the balance on hand.

5) There shall be written procedures for utilization of the "stat" medicine cabinet with provisions for prompt replacement of used items.

6) The pharmacist shall inspect the "stat" medicine cabinet at least monthly replacing outdated drugs and reconciliation of its prior usage. Information obtained shall be included in a monthly report.

(2) Unnecessary Drugs—General. Each resident's drug regimen must be free from unnecessary drugs. An unnecessary drug is any drug when used:

(a) In excessive dose (including duplicate drug therapy); or

(b) For excessive duration; or

(c) Without adequate monitoring; or

(d) Without adequate indications for its use; or

(e) In the presence of adverse consequences which indicate the dose should be reduced or discontinued; or

(f) Any combinations of the reasons stated.

(3) Unnecessary Psychotropic Medications and as-need (PRN) use.

(a) A psychotropic drug is any drug that affects brain activities associated with mental processes and behavior. These drugs include, but are not limited to, drugs in the following categories:

1) Anti-psychotic.

2) Anti-depressant.

3) Anti-anxiety.

4) Hypnotic.

(b) Psychotropic Drugs. Based on a comprehensive assessment of a resident, the facility must ensure that:

1) Residents who have not used psychotropic drugs are not given these drugs unless the medication is necessary to treat a specific condition as diagnosed and documented in the clinical record.

2) Residents who use psychotropic drugs receive gradual dose reductions, and behavioral interventions, unless

clinically contraindicated, in an effort to discontinue these drugs.

(c) Residents do not receive psychotropic drugs pursuant to a PRN order unless that medication is necessary to treat a diagnosed specific condition that is documented in the clinical record.

(d) PRN orders for psychotropic drugs are limited to 14 days.

(e) Except as provided in 420-5-10-.14(4), if the attending physician or prescribing practitioner believes that it is appropriate for the PRN order to be extended beyond 14 days, he or she should document their rationale in the resident's medical record and indicate the duration for the PRN order.

(f) PRN orders for anti-psychotic drugs are limited to 14 days and cannot be renewed unless the attending physician or prescribing practitioner evaluates the resident for the appropriateness of that medication.

(4) Medication Errors. The facility must ensure that its medication error rates are not 5 percent or greater; and residents are free of any significant medication errors.
Author: Patricia E. Ivie, Nancy L. Eady
Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.
History: **Repealed and Replaced:** Filed July 19, 1996; effective August 23, 1996. **Repealed and New Rule:** Published September 30, 2026; effective November 14, 2026.

420-5-10-.16 Laboratory, Radiology, and Other Diagnostic Services.

(1) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. If the facility provides its own laboratory services, the services must meet the applicable requirements for laboratories.

(a) If the facility provides blood bank and transfusion services, it must meet the applicable requirements for laboratories.

(b) If the laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory must be certified in the appropriate specialties and subspecialties of services.

(2) The facility must provide or obtain laboratory services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services. If the facility does

not provide laboratory services on site, it must have an agreement to obtain these services from a laboratory that meets the applicable requirements.

(3) The facility must:

(a) Provide or obtain laboratory services only when ordered by a physician; physician assistant; or nurse practitioner in accordance with state law, including scope of practice laws.

(b) Promptly notify the ordering physician, physician assistant, or nurse practitioner of laboratory results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician’s orders.

(4) The facility must assist the resident in making transportation arrangements to and from the source of service if the resident needs assistance.

(5) The facility must file in the resident's clinical record laboratory reports that are dated and contain the name and address of the testing laboratory.

(6) Radiology and Other Diagnostic Services. The facility must provide or obtain radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services.

(a) If the facility provides its own diagnostic services, the services must meet the applicable conditions of participation for hospitals.

(b) If the facility does not provide its own diagnostic services, it must have an agreement to obtain these services from a provider or supplier that is approved to provide these services under Medicare

(7) The facility must:

(a) Provide or obtain radiology and other diagnostic services only when ordered by a physician; physician assistant; or nurse practitioner in accordance with state law, including scope of practice laws.

(b) Promptly notify the ordering physician, physician assistant, or nurse practitioner of results that fall outside of clinical reference ranges in accordance with facility policies and procedures for notification of a practitioner or per the ordering physician’s orders.

(c) Assist the resident in making transportation arrangements to and from the source of service if the resident needs assistance.

(d) File in the resident's clinical record signed and dated reports of radiologic and other diagnostic services.

Author: Patricia E. Ivie, Nancy L. Eady
Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.
History: Repealed and Replaced: Filed July 19, 1996; effective August 23, 1996. **Amended:** Filed June 23, 2004; effective July 28, 2004. **Repealed and New Rule:** Published September 30, 2026; effective November 14, 2026.

420-5-10-.17 Dental Services.

(1) The facility must assist residents in obtaining routine and 24-hour emergency dental care.

(a) Skilled Nursing Facilities. A facility:

1) Must provide or obtain from an outside resource, in accordance with Section 483.70(f) of Title 42 Code of Federal Regulations, routine and emergency dental services to meet the needs of each resident.

2) May charge a Medicare resident an additional amount for routine and emergency dental services.

3) Must have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility.

4) Must, if necessary, assist the resident:

a. In making appointments.

b. By arranging for transportation to and from the dentist's office.

c. Promptly, within 3 days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.

(b) Nursing Facilities. The facility:

1) Must assist residents in obtaining routine and 24-hour emergency dental care from an outside resource, including but not limited to the following dental services to meet the needs of each resident:

a. Routine dental services (to the extent covered under the state plan).

b. Emergency dental services.

2) Must, if necessary, assist the resident:

a. In making appointments.

b. By arranging for transportation to and from the dental services location.

c. Promptly, within three (3) days, refer residents with lost or damaged dentures for dental services. If a referral does not occur within 3 days, the facility must provide documentation of what they did to ensure the resident could still eat and drink adequately while awaiting dental services and the extenuating circumstances that led to the delay.

3) Have a policy identifying those circumstances when the loss or damage of dentures is the facility's responsibility and may not charge a resident for the loss or damage of dentures determined in accordance with facility policy to be the facility's responsibility.

4) Must assist residents who are eligible and wish to participate to apply for reimbursement of dental services as an incurred medical expense under the state plan.

Author: Patricia E. Ivie, Nancy L. Eady
Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.
History: Repealed and Replaced: Filed July 19, 1996; effective August 23, 1996. **Amended:** Filed November 18, 1999; effective December 23, 1999. **Repealed and New Rule:** Published September 30, 2026; effective November 14, 2026.

420-5-10-.18 Food and Nutrition Services.

(1) The facility must provide each resident with a nourishing, palatable, well-balanced diet that meets the daily nutritional and special dietary needs, taking into consideration the preferences of each resident.

(a) Staffing - The facility must employ sufficient staff with the appropriate competencies and skill sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care, and the number, acuity and diagnoses of the facility's resident population in accordance with the facility assessment. This includes:

1) A qualified dietitian, and/or food service manager, or other clinically qualified nutrition professional either full-time, part-time, or on a consultant basis. A qualified dietitian or other clinically qualified nutrition professional is one who:

a. Holds a bachelor's or higher degree granted by a regionally accredited college or university in the United States (or an equivalent foreign degree) with completion of the academic requirements of a program in nutrition or dietetics accredited by an appropriate national accreditation organization recognized for this purpose.

b. Has completed at least 900 hours of supervised dietetics practice under the supervision of a registered dietitian or nutrition professional.

c. Is licensed or certified as a dietitian or nutrition professional by the state in which the services are performed. In a state that does not provide for licensure or certification, the individual will be deemed to have met this requirement if he or she is recognized as a "registered dietitian" by the Commission on Dietetic Registration or its successor organization or meets the requirements of paragraphs (a)(1)a. and b. of this section.

d. For dietitians hired or contracted with prior to November 28, 2016, meets these requirements no later than 5 years after November 28, 2016, or as required by state law.

2) If a qualified dietitian or other clinically qualified nutrition professional is not employed full-time, the facility must designate a person to serve as the director of food and nutrition services who receives frequently scheduled consultations from a qualified

dietitian or other clinically qualified nutrition professional.

a. The director of food and nutrition services must at a minimum meet one of the following qualifications:

(i) A certified dietary manager; or

(ii) A certified food service manager; or

(iii) Has similar national certification for food service management and safety from a national certifying body; or

(iv) Has an associate's or higher degree in food service management or in hospitality, if the course study includes food service or restaurant management, from an accredited institution of higher learning; or

(v) Has 2 or more years of experience in the position of director of food and nutrition services in a nursing facility setting and has completed a course of study in food safety and management, by no later than October 1, 2023, that includes topics integral to managing dietary operations including, but not limited to, foodborne illness, sanitation procedures, and food purchasing/receiving.

3) A qualified dietitian or other clinically qualified nutrition professional and consultant from a qualified dietitian or other clinically qualified nutrition professional means one who is currently licensed in the state of Alabama in accordance with the provisions contained in current state statutes as governed by the Alabama Board of Examiners for Dietetic/Nutrition Practice.

(2) Staffing. The facility must employ sufficient support personnel with the appropriate competencies and skill sets to carry out the functions of the food and nutrition service, taking into consideration resident assessments, individual plans of care, and the number, acuity, and diagnoses of the facility's resident population in accordance with the facility assessment.

(a) The facility must provide sufficient support personnel competent to carry out the functions of the food and nutrition service.

(b) A member of the food and nutrition services staff must participate on the interdisciplinary team.

(3) Menus and Nutritional Adequacy. Menus must:

(a) Meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences.

(b) Be prepared in advance.

(c) Be followed.

(d) Reflect, based on a facility's reasonable efforts, the religious, cultural, and ethnic needs of the resident population, as well as input received from residents and resident groups.

(e) Be updated periodically.

(f) Be reviewed by the facility's dietitian or other clinically qualified nutrition professional for nutritional adequacy.

(g) Nothing in this paragraph should be construed to limit the resident's right to make personal dietary choices.

(4) Food and Drink. Each resident receives and the facility provides:

(a) Food prepared by methods that conserve nutritive value, flavor, and appearance.

(b) Food and drink that is palatable, attractive, and at the proper temperature.

(c) Food prepared in a form designed to meet individual needs.

(d) Appealing options of similar nutritive value to residents who choose not to eat food that is initially served or who request a different meal choice.

(e) Food that accommodates resident allergies, intolerances, and preferences.

(f) Drinks, including water and other liquids consistent with resident needs and preferences and sufficient to maintain resident hydration.

(5) Therapeutic Diets. Therapeutic diets must be prescribed by the attending physician. The attending physician may delegate to a registered or licensed dietitian, licensed by the Alabama Board of Examiners for Dietetics and Nutritionists the task of prescribing a resident's diet, including a therapeutic diet, to the extent allowed by state law.

(6) Frequency of Meals.

(a) Each resident receives and the facility provides at least three meals daily, at regular times comparable to normal mealtimes in the community, or in accordance with resident needs, preferences, requests, and plan of care.

(b) There must be no more than 14 hours between a substantial evening meal and breakfast the following day, up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

(c) Suitable, nourishing alternative meals and snacks must be provided to residents who want to eat at non-traditional times or outside of scheduled meal service times, consistent with the resident plan of care.

(7) Assistive Devices. The facility must provide special eating equipment and utensils for residents who need them and appropriate assistance to ensure that residents can use the assistive devices when consuming meals and snacks.

(8) Food Safety Requirements. The facility must:

(a) Procure food from sources approved or considered satisfactory by federal, state or local authorities.

1) This may include food items obtained directly from local producers, subject to applicable state and local laws or regulations.

2) This provision does not prohibit or prevent facilities from using produce grown in facility gardens,

subject to compliance with applicable safe growing and food-handling practices.

3) This provision does not preclude residents from consuming foods not procured by the facility.

4) Have a policy regarding use and storage of foods brought to residents by family and other visitors to ensure safe and sanitary storage, handling, and consumption.

(b) Store, prepare, distribute, and serve food in accordance with professional standards for food service safety.

(c) Dispose of garbage and refuse properly.

(9) Feeding Assistant Program Requirements.

(a) Facility staff who are not healthcare personnel, (the facility administrator, activity staff, clerical staff, laundry and housekeeping staff, or other), can be used as feeding assistants upon successful completion of an approved training program.

1) Volunteers and family members may assist residents with feeding and drinking, without completing an approved training program. A feeding assistant shall only assist residents to eat or drink who have no complicated feeding problems and who have no known behaviors at mealtimes. If a resident is determined, by the facility, to meet the criteria for having a feeding assistant, then the facility must specify that the resident will be assisted by a feeding assistant on the care plan.

(b) Examples of complicated feeding problems include: difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings. Residents with a clinical condition, such as the conditions listed above, require the employee providing feeding or hydration services to be a licensed healthcare professional or certified nurse aide.

(c) The facility must base resident selection on the interdisciplinary team’s assessment and the resident’s assessment and plan of care. A feeding assistant must work under the direct supervision of a registered nurse or licensed practical nurse in a dining room or other common area.

(d) The feeding assistant is not permitted to perform other nursing or nursing-related duties (for example, measuring or recording output, transferring, and toileting). In an emergency, a feeding assistant must immediately call a supervisory nurse on the resident call system, or other appropriate means of emergency notification.

(e) Feeding Assistant Definition. Paid feeding assistant means a person who does not meet the definition of healthcare personnel and who is paid by a nursing home to assist residents who have no feeding complications with the activities of eating and drinking. The feeding assistant is not permitted to provide any other nursing or nursing related service. Paid feeding assistants must be at least 16 years old. A feeding assistant must work under the direct supervision of a registered nurse or licensed practical nurse in a dining room or other common area.

1) Nurse aides who are on the Nurse Aide Abuse Registry and who have been disqualified from working as a nurse aide may not work as a feeding assistant. A feeding assistant does not include a person who is a:

a. Licensed health professional or registered dietitian;

b. Volunteers without monetary compensation;

c. Certified nurse aide;

d. Family member.

(f) Feeding Assistant Training Requirements.

1) Feeding assistant training programs must require enrolled individuals to successfully complete an approved training program, which includes the following federally- mandated topics, covered during 9 hours of classroom instruction and hands on training:

a. Feeding techniques.

b. Assistance with feeding and hydration.

c. Communication and interpersonal skills.

d. Appropriate responses to resident behavior.

e. Safety and emergency procedures, including the Heimlich maneuver.

f. Infection control.

g. Resident rights.

h. Recognizing changes in residents that are inconsistent with their normal behaviors and the importance of reporting these changes to the supervisory nurse.

i. Abuse, neglect, and misappropriation of resident property including reporting requirements.

j. Dementia.

2) Training must include an experienced staff member demonstrating the correct way to feed a resident who requires minimal assistance with feeding, including appropriate cueing, moderate assistance with feeding, and a resident who requires total assistance with feeding.

3) The feeding assistant training program must also provide instruction on the following topics:

a. The resident population who will be served by the feeding assistant in a facility-based program. The facility-based training program curriculum must include training specific to the identified population type(s). This training must include, but is not limited to:

(i) Characteristics of the population, such as the population member's physical, social and mental health needs, and specific medications or treatment needed by the residents.

b. Meeting the needs of persons with a dual diagnosis (co-occurrences of mental health disorders and alcohol and/or drug dependence or abuse) and maintaining or increasing his or her social participation.

4) Feeding assistants who have been trained by another facility's training program, must be trained for the specific needs of a facility's population.

5) Programs may choose to add increased training requirements.

6) Training programs must stress the only direct, hands-on duty a feeding assistant is permitted to perform is assisting residents to eat or drink who have no complicated feeding problems and who have no known behaviors at mealtime.

7) Feeding assistant training programs must use a training curriculum, which has been pre-approved by the department and determined to comply with the federal requirements. Entities are allowed to choose one of the following pre-approved, standardized curriculum models:

a. Assisting with Nutrition and Hydration in Long-Term Care. Hartman Publishing Inc.; or

b. Assisted Dining: The Role and Skills of Feeding Assistants. Walker, Bonnie L and Cole, Claire S. American Healthcare Association.

8) Although the pre-approved standardized training curriculums include additional skill information (e.g., output, special care needs for resident with dysphagia, etc.), the instructor must stress the feeding assistant will not be permitted to perform any other hands-on duty, beyond assisting residents to eat and drink who have no complicated feeding problems and who have no known behaviors at meals.

9) An individual may not provide hands-on assistance with feeding or hydrating residents unless the individual has successfully completed the following:

a. A state-approved training program for feeding assistants, including additional instruction on any selected resident population.

b. After completing the training course, the individual must pass a state-approved standardized written quiz with a minimum score of 80 percent. The individual may request the quiz to be administered orally. Instructors should consider the needs of persons who have limited English proficiency or reading difficulties.

c. Successfully completing demonstration of:

(i) feeding residents with minimal assistance or moderate assistance with cueing and total feeding of resident.

(ii) Heimlich maneuver.

(iii) appropriate hand-washing techniques.

10) Programs may choose to add increased testing requirements.

11) Students who do not successfully pass the initial competency evaluation will be allowed the opportunity to review the training materials and retake the test a maximum of two additional times. Therefore, the student may only take the test a total of three times. The program must document the failure, opportunity for review, and subsequent retake testing date.

(g) Feeding Assistant Instructor Requirements. Only the following licensed healthcare professionals can serve as lead instructors: R.N., L.P.N., registered dietitian (R.D.), speech therapist (S.T.), occupational therapist (O.T.). These individuals must have experience in long-term care with 6 months' experience in the management of persons with dementia. Experienced certified nursing assistants (CNAs) and other individuals may assist with the training and feeding demonstrations, if appropriately supervised.

(h) Records. Feeding assistants must receive an annual inservice on relevant feeding assistant topics (any topic area included in the curriculum is appropriate). In addition, feeding assistants must be evaluated on a yearly basis to document that skill performance and feeding competence is satisfactory.

1) Feeding assistant training programs must maintain the following records:

a. For a minimum of 3 years, all students' written examinations, (skills checklists) and other relevant training records.

b. Documentation of the training conducted and identification of the instructor conducting the training.

c. Record of all individuals who have successfully completed the feeding assistant training and competency testing program.

2) Training programs must maintain the security of the test materials to ensure disclosure or forgery does not occur.

3) Facilities employing feeding assistants must maintain the following records:

a. Feeding assistants must have in their personnel file evidence of the following:

(i) Evidence of having successfully completed an approved feeding assistant training and competency testing program.

(ii) Evidence of annual inservice sessions(s), relating to feeding assistant duties.

(iii) Evidence of an annual evaluation, determining a feeding assistant's continued competence in feeding residents.

b. A feeding assistant roster which records all individuals employed by the facility as feeding assistants who successfully completed the feeding assistant training and competency evaluation.

c. The selected resident's medical record, documenting no complicated feeding condition exists.

(i) Approval Process of Feeding Assistant Training Programs. A facility must submit to the Division of Healthcare Facilities (DHCF) in writing the curriculum the facility will utilize in their feeding assistant training program.

(10) Paid Feeding Assistants.

(a) State approved training course. A facility may use a paid feeding assistant if:

1) The feeding assistant has successfully completed a state-approved training course that meets the requirements of § 483.160 before feeding residents.

2) The use of feeding assistants is consistent with state law.

(b) Supervision.

1) A feeding assistant must work under the supervision of an RN or LPN.

2) In an emergency, a feeding assistant must call a supervisory nurse for help.

(c) Resident selection criteria.

1) A facility must ensure that a feeding assistant provides dining assistance only for residents who have no complicated feeding problems.

2) Complicated feeding problems include, but are not limited to, difficulty swallowing, recurrent lung aspirations, and tube or parenteral/IV feedings.

3) The facility must base resident selection on the interdisciplinary team's assessment and the resident's latest assessment and plan of care. Appropriateness for this program should be reflected in the comprehensive care plan.

Author: Rick Harris, Dana Billingsley, Nancy L. Eady
Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.
History: Repealed and Replaced: Filed July 19, 1996; effective August 23, 1996. **Amended:** Filed November 18, 1999; effective December 23, 1999. **Amended:** Filed June 18, 2002; effective July 23, 2002. **Amended:** Filed September 18, 2003; effective October 23, 2003. **Amended:** Filed June 23, 2004; effective July 28, 2004. **Repealed and New Rule:** Published September 30, 2026; effective November 14, 2026.

Ed. Note: History: Chapter 420-5-10 "Nursing Homes" (Rules 420-5-10-.01 through 420-5-10-.11 filed September 1, 1982. Rule 420-05-10-.05. **Amended:** Filed November 19, 1987. Rule 420-5-10-.07. **Amended:** Filed November 19, 1987. Entire Chapter repealed and new chapter adopted in lieu thereof: Filed November 21, 1988. Entire Chapter repealed and new chapter adopted in lieu thereof: Filed July 19, 1996.

420-5-10-.19 Specialized Rehabilitative Services.

(1) Provision of Services. If specialized rehabilitative services such as, but not limited to, physical therapy, speech-language

pathology, occupational therapy, and health rehabilitative services for mental illness and intellectual disability or services of a lesser intensity are required in the resident's comprehensive plan of care, the facility must:

(a) Provide the required services; or

(b) Obtain the required services from an outside resource in accordance with Section 420-5-10-.03 from a provider of specialized rehabilitative services which is not excluded from participating in any state healthcare programs.

(2) Qualifications. Specialized rehabilitative services must be provided under the written order of a physician by qualified personnel.

Author: Patricia E. Ivie, Nancy L. Eady
Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.
History: **New Rule:** Published September 30, 2026; effective November 14, 2026.

420-5-10-.20 Quality Assurance and Performance Improvement (QAPI) Program.

(1) Each LTC facility, including a facility that is part of a multiunit chain, must develop, implement, and maintain an effective, comprehensive, data-driven QAPI Program that focuses on indicators of the outcomes of care and quality of life. The facility must:

(a) Maintain documentation and demonstrate evidence of its ongoing QAPI Program that meets the requirements of this section. This may include but is not limited to systems and reports demonstrating systematic identification, reporting, investigation, analysis, and prevention of adverse events; and documentation demonstrating the development, implementation, and evaluation of corrective actions or performance improvement activities.

(b) Present its QAPI Plan to the state Survey Agency no later than 1 year after the promulgation of this regulation;

(c) Present its QAPI Plan to a state Survey Agency or federal surveyor at each annual recertification survey and upon request during any other survey and to CMS upon request.

(d) Present documentation and evidence of its ongoing QAPI Program's implementation and the facility's compliance with requirements to a state Survey Agency, federal surveyor, or CMS upon request.

(e) Program Design and Scope. A facility must design its QAPI Program to be ongoing, comprehensive, and to address the full range of care and services provided by the facility. It must:

1) Address all systems of care and management practices.

2) Include clinical care, quality of life, and resident choice.

3) Utilize the best available evidence to define and measure indicators of quality and facility goals that reflect processes of care and facility operations that have been shown to be predictive of desired outcomes for residents of an SNF or NF.

4) Reflect the complexities, unique care, and services that the facility provides.

(f) Governance and Leadership. The governing body and/or executive leadership (or organized group or individual who assumes full legal authority and responsibility for operation of the facility) is responsible and accountable for ensuring that:

1) An ongoing QAPI Program is defined, implemented, and maintained and addresses identified priorities.

2) The QAPI Program is sustained during transitions in leadership and staffing;

3) The QAPI Program is adequately resourced, including ensuring staff time, equipment, and technical training as needed;

4) The QAPI Program identifies and prioritizes problems and opportunities that reflect organizational process, functions, and services provided to residents based on performance indicator data, and resident and staff input, and other information.

5) Corrective actions address gaps in systems and are evaluated for effectiveness.

6) Clear expectations are set around safety, quality, rights, choice, and respect.

(g) Disclosure of Information. A state or the secretary of the federal Health and Human Resources Department may not require disclosure of the records of such committee except in so far as such disclosure is related to the compliance of such committee.

(h) Sanctions. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions.

(2) Program Feedback, Data Systems and Monitoring.

(a) A facility must establish and implement written policies and procedures for feedback, data collections systems, and monitoring, including adverse event monitoring. The policies and procedures must include, at a minimum, the following:

1) Facility maintenance of effective systems to obtain and use feedback and input from direct care staff, other staff, residents, and resident representatives, including how such information will be used to identify problems that are high risk, high volume, or problem-prone, and opportunities for improvement.

2) Facility maintenance of effective systems to identify, collect, and use data and information from all departments, including but not limited to the facility assessment and including how such information will be used to develop and monitor performance indicators.

3) Facility development, monitoring, and evaluation of performance indicators, including the methodology and frequency for such development, monitoring, and evaluation.

4) Facility adverse event monitoring, including the methods by which the facility will systematically identify, report, track, investigate, analyze, and use data and information relating to adverse events in the facility, including how the facility will use the data to develop activities to prevent adverse events.

(b) Program Systematic Analysis and Systemic Action.

1) The facility must take actions aimed at performance improvement and, after implementing those actions, measure its success, and track performance to ensure that improvements are realized and sustained.

2) The facility will develop and implement policies addressing:

a. How they will use a systematic approach to determine underlying causes of problems impacting larger systems.

b. How they will develop corrective actions that will be designed to effect change at the systems

level to prevent quality of care, quality of life, or safety problems.

c. How the facility will monitor the effectiveness of its performance improvement activities to ensure that improvements are sustained.

(c) Program Activities.

1) The facility must set priorities for its performance improvement activities that focus on high-risk, high-volume, or problem-prone areas; consider the incidence, prevalence, and severity of problems in those areas; and affect health outcomes, resident safety, resident autonomy, resident choice, and quality of care.

2) Performance improvement activities must track medical errors and adverse resident events, analyze their causes, and implement preventive actions and mechanisms that include feedback and learning throughout the facility.

3) As part of their performance improvement activities, the facility must conduct distinct performance improvement projects. The number and frequency of improvement projects conducted by the facility must reflect the scope and complexity of the facility's services and available resources, as reflected in the facility assessment.

4) Improvement projects must include at least annually a project that focuses on high-risk or problem-prone areas identified through data collection and analysis.

(d) Quality Assessment and Assurance. The quality assessment and assurance committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI Program.

1) The committee must:

a. Develop and implement appropriate plans of action to correct identified quality deficiencies.

b. Regularly review and analyze data, including data collected under the QAPI Program and data resulting from drug regimen reviews, and act on available data to make improvements.

(3) Quality Assessment and Assurance (QAA) Committee.

(a) A facility must maintain a QAA Committee consisting at a minimum of:

1) The director of nursing services.

2) The medical director or his/her designee.

3) At least three other members of the facility's staff, at least one of whom must be the administrator, owner, a board member or other individual in a leadership role.

4) The infection preventionist.

(b) The QAA Committee reports to the facility's governing body, or designated person(s) functioning as a governing body regarding its activities, including implementation of the QAPI Program.

(c) The QAA Committee must meet at least quarterly and as needed to coordinate and evaluate activities under the QAPI Program, such as identifying issues with respect to which QAA activities, including performance improvement projects required under the QAPI program, are necessary.

Author: Nancy L. Eady
Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.
History: New Rule: Published September 30, 2026; effective November 14, 2026.

420-5-10-.21 Infection Control.

(1) The facility must establish and maintain an infection prevention and control program (IPCP) designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable disease and infection.

(a) Infection Prevention and Control Program. The facility must establish an infection control program that must include, at a minimum, the following elements:

1) A system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, volunteers, visitors, and other individuals providing services under a contractual arrangement based upon the facility assessment conducted according to 420-5-10-.19 and following accepted national standards.

2) Written standards, policies, and procedures for the program, which must include, but are not limited to:

a. A system of surveillance designed to identify possible communicable diseases or infections before they can spread to other persons in the facility.

b. When and to whom possible incidents of communicable disease or infections should be reported.

c. Standard and transmission-based precautions to be followed to prevent spread of infections.

d. When and how isolation should be used for a resident; including but not limited to:

(i) The type and duration of the isolation, depending upon the infectious agent or organism involved.

(ii) A requirement that isolation should be the least restrictive possible for the resident under the circumstances.

e. The circumstances under which the facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease.

f. The hand hygiene procedures to be followed by staff involved in direct resident contact.

g. A system for recording incidents identified under the facility's IPCP and the corrective actions taken by the facility.

3) Linens. Personnel must handle, store, process, and transport linens to prevent the spread of infection.

4) Annual Review. The facility will conduct an annual review of its IPCP and update their program, as necessary.

(2) IPCP. The facility must establish an infection prevention and control program (IPCP) that must include, at a minimum, an

antibiotic stewardship program that includes antibiotic use protocols and a system to monitor antibiotic use.

(3) Infection Preventionist (IP). The facility must designate one or more individual(s) as the IP who is responsible for the facility's IPCP. The IP must:

(a) Have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field.

(b) Be qualified by education, training, experience or certification.

(c) Work at least part-time at the facility.

(d) Have completed specialized training in infection prevention and control.

(4) Tuberculosis (TB) Screening:

(a) Resident Screening.

1) As part of the resident admission procedure, a two-step tuberculin (PPD-Mantoux) skin test shall be administered prior to or upon admission to all new residents unless there is documentation of a previous positive reaction. The two-step method should detect the boosting phenomenon that might be misinterpreted as a skin test conversion. Testing administered prior to admission shall be within 30 days of admission date. Results shall be recorded in the permanent records of the facility.

2) History of Bacille Calmetta Guerin (BCG) vaccination does not preclude an initial screening test, and a reaction of 10 mm or more indurations shall be managed as a tuberculous infection.

3) At the time of admission, any resident found to have a significant tuberculin skin test reaction (10 mm or greater) or with symptoms suggestive of TB shall be evaluated for active TB disease by clinical examination and chest roentgenogram. Sputum specimen, if obtainable, shall be collected and sent to the state Health Department Laboratory for smear and culture studies. Routine chest roentgenogram at admission remains an option at the discretion of the nursing facility. In the

absence of clinical symptoms, annual chest roentgenograms are not recommended.

4) Sputum of acid-fast smear and mycobacterial culture shall be obtained promptly on any tuberculin reactor who develops a persistent cough or fever or manifests an abnormal chest roentgenogram compatible with TB. Any resident, regardless of skin test results, with a persistent cough or fever or other symptoms suggestive of TB shall first have sputum collected and submitted immediately to the state Health Department Laboratory for smear and culture studies, followed by a clinical examination and chest roentgenogram.

5) Residents who have a documented history of a positive (greater than 10 mm induration) PPD tuberculin test, adequate treatment for disease, or adequate preventive therapy for infection shall be exempt from further screening unless they develop signs or symptoms suggestive of TB.

6) Routine annual TB skin testing of residents is not recommended for every nursing facility. The Infection Control Plan for each facility shall establish the need and frequency of repeat or annual TB skin testing based upon the risk of transmission of TB infection in that facility and the surrounding community.

7) All residents with a documented negative tuberculin test shall be retested within 7 working days after notice of exposure to a suspected or diagnosed case, using the single-step Mantoux method. Contacts having a tuberculin skin test with a 5 mm or greater induration, and tuberculin converters should have follow-up examinations including a chest roentgenogram and clinical evaluation. Converters are defined as newly infected persons, without documented exposure information, whose tuberculin skin test increases as follows:

a. For persons under age 35 the skin test must increase by at least 10 mm from most recent test results.

b. For persons aged 35 and older the skin test must increase by at least 15 mm from most recent test results.

(b) Employee Screening.

1) As part of the pre-employment procedure, a two step tuberculin (PPD-Mantoux) skin test shall be administered to all new employees as soon as employment begins unless there is documentation of a previous positive reaction or documentation of a negative skin test within the past 12 months. A single-step skin test is sufficient for new employees with documented negative test within the previous 12 months. The two-step tuberculin skin testing should detect the boosting phenomenon that might be misinterpreted as a skin test conversion. Results shall be recorded in the permanent records of the facility.

2) A history of BCG vaccination does not preclude an initial screening test, and a reaction of 10 mm or more indurations shall be managed as a TB infection.

a. Any healthcare worker (HCW), at the time of employment, found to have a significant tuberculin skin test reaction (10 mm or greater) or with symptoms suggestive of TB shall be evaluated by clinical examination and chest roentgenogram. Sputum specimen, if obtainable, shall be collected and sent to the State Health Department Laboratory for smear and culture.

b. HCWs who have a documented history of a positive PPD test, adequate treatment for disease, or adequate preventive therapy for infection shall be exempt from further screening unless they develop signs or symptoms suggestive of TB.

c. Routine annual TB skin testing of HCWs is not recommended for every nursing facility. PPD-negative HCWs shall undergo repeat PPD testing at regular intervals as determined by the nursing facility’s risk assessment. The Infection Control Plan for each facility should establish the need and frequency of repeat or annual TB skin testing based upon the risk of transmission of TB in that facility and surrounding community.

d. All HCWs with documented negative tuberculin test shall be retested using the single-step Mantoux method within 7 working days after notice of exposure to a suspected or diagnosed case of TB

if appropriate precautions were not in place at the time of exposure. All HCWs with newly recognized positive PPD test results shall be evaluated promptly for active TB. Contacts having a tuberculin skin test with a 5 mm or greater induration, and tuberculin converters shall have follow-up examinations including a chest roentgenogram and clinical evaluation. Sputum specimen, if obtainable, should be sent to the State Health Department Laboratory for smear and culture. Converters are defined as newly infected persons, without documented exposure information, whose tuberculin test increases as follows:

(i) For persons under age 35, the test must increase by at least 10 mm within the past 2 years.

(ii) For persons aged 35 and older, the skin test must increase by at least 15 mm within the past 2 years.

e. Routine chest radiographs are not required for asymptomatic, PPD- negative HCWs. HCWs with positive PPD test results shall have chest radiographs as part of the initial evaluation of their PPD test; if negative, repeat chest radiographs are not needed unless symptoms develop that could be attributed to TB. However, more frequent monitoring for symptoms of TB may be considered for recent converters and other PPD-positive HCWs who are at increased risk for developing active TB (e.g., HIV- infected or otherwise severely immunocompromised HCWs).

(c) Treatment of Latent Infection.

1) Infected employees and residents with no current disease, who are 34 years of age and under, shall be offered preventive therapy (isoniazid) in accordance with the American Thoracic Society, Centers for Disease Control and Prevention, American College of Chest Physicians, and the Alabama State TB Control Program Guidelines. Employees and residents aged 35 and over who have significant skin tests may be offered preventive therapy depending upon each individual’s complete evaluation.

(d) Role of the Health Department.

1) Any employee or resident with suspected or diagnosed TB disease must be reported to the local health department immediately.

2) Epidemiologic investigation will be performed by trained health department staff on all employees and residents with diagnosed or suspected disease.

3) Further information regarding TB screening of employees and residents may be obtained by contacting the local county health department or the Division of TB Control of the State Health Department.

(e) Two-Step Testing.

1) Nursing homes may choose to use either of the methods outlined below when administering the two-step (test-retest) tuberculin skin test. The Infection Control Plan for each facility shall designate which method is more appropriate for the facility and that method must be consistently utilized. The use of the two-step tuberculin skin test should detect the boosting phenomenon that might be misinterpreted as a skin test conversion. The process is particularly important when repeat testing is likely.

a. Method 1:

(i) Apply first test.

(ii) Read result in 7 days.

(iii) If result is positive (greater than 10 mm of induration), follow recommendation for appropriate follow-up of positive skin test.

(iv) If result is negative (0-9 mm of induration), apply second test (same day).

(v) Read result of second test 48-72 hours later.

(vi) Use result of second test as baseline.

b. Method 2:

(i) Apply first test.

(ii) Read test in 48-72 hours.

(iii) If result is positive (greater than 10 mm of induration), follow recommendation for appropriate follow-up of positive skin test.

(iv) If result is negative (0-9 mm of induration), apply second test 1-3 weeks later.

(v) Read result of second test 48-72 hours later.

(vi) Use result of second test as baseline.

(5) Influenza and Pneumococcal Immunizations.

(a) Influenza. The facility must develop policies and procedures to ensure that:

1) Before offering the influenza immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization.

2) Each resident is offered an influenza immunization October 1 through March 31 annually, unless the immunization is medically contraindicated, or the resident has already been immunized during this time period;

3) The resident or the resident's representative has the opportunity to refuse immunization.

4) The resident's medical record includes documentation that indicates, at a minimum, the following:

a. That the resident or resident's representative was provided education regarding the benefits and potential side effects of influenza immunization.

b. That the resident either received the influenza immunization or did not receive the influenza immunization due to medical contraindications or refusal.

(b) Pneumococcal Disease. The facility must develop policies and procedures to ensure that:

1) Before offering the pneumococcal immunization, each resident or the resident's representative receives education regarding the benefits and potential side effects of the immunization.

2) Each resident is offered a pneumococcal immunization, unless the immunization is medically contraindicated, or the resident has already been immunized.

3) The resident or the resident's representative can refuse immunization.

4) The resident's medical record includes documentation that indicates, at a minimum, the following:

a. That the resident or resident's representative was provided education regarding the benefits and potential side effects of pneumococcal immunization.

b. That the resident either received the pneumococcal immunization or did not receive the pneumococcal immunization due to medical contraindication or refusal.

Author: Patricia E. Ivie, Jimmy D. Prince, Nancy L. Eady
Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.
History: New Rule: Published September 30, 2026; effective November 14, 2026.

420-5-10-.22 Compliance and Ethics Program.

(1) Compliance and Ethics Program.

(a) Definitions. For purposes of this section, the following definitions apply:

1) Compliance and ethics program means, with respect to a facility, a program of the operating organization that:

a. Has been reasonably designed, implemented, and enforced so that it is likely to be effective in preventing and detecting criminal, civil, and

administrative violations under the Act and in promoting quality of care.

b. Includes, at a minimum, the required components specified in paragraph (c) of this section.

2) High-level personnel means individual(s) who have substantial control over the operating organization or who have a substantial role in the making of policy within the operating organization.

3) Operating organization means the individual(s) or entity that operates a facility.

(b) General Rule. The operating organization for each facility must have in operation a compliance and ethics program (as defined in paragraph (a) of this section) that meets the requirements of this section.

(c) Required Components for All Facilities.

1) The operating organization for each facility must develop, implement, and maintain an effective compliance and ethics program that contains, at a minimum, the following components:

a. Established written compliance and ethics standards, policies, and procedures to follow that are reasonably capable of reducing the prospect of criminal, civil, and administrative violations under the Act, and promote quality of care, which include, but are not limited to, the designation of an appropriate compliance and ethics program contact to which individuals may report suspected violations, as well as an alternate method of reporting suspected violations anonymously without fear of retribution; and disciplinary standards that set out the consequences for committing violations for the operating organization's entire staff; individuals providing services under a contractual arrangement; and volunteers, consistent with the volunteers' expected roles.

b. Assignment of specific individuals within the high-level personnel of the operating organization with the overall responsibility to oversee compliance with the operating organization's compliance and ethics program's standards, policies, and procedures, such as, but not limited to, the chief executive officer (CEO), members of the board of directors, or directors of major divisions in the operating organization.

c. Sufficient resources and authority to the specific individuals designated in paragraph (c) b. of this section to reasonably assure compliance with such standards, policies, and procedures.

d. Due care not to delegate substantial discretionary authority to individuals who the operating organization knew, or should have known through the exercise of due diligence, had a propensity to engage in criminal, civil, and administrative violations under the Social Security Act.

e. The facility takes steps to effectively communicate the standards, policies, and procedures in the operating organization's compliance and ethics program to the operating organization's entire staff; individuals providing services under a contractual arrangement; and volunteers, consistent with the volunteers' expected roles. Requirements include, but are not limited to, mandatory participation in training as set forth at § 483.95(f) or orientation programs or disseminating information that explains in a practical manner what is required under the program.

f. The facility takes reasonable steps to achieve compliance with the program's standards, policies, and procedures. Such steps include, but are not limited to, utilizing monitoring and auditing systems reasonably designed to detect criminal, civil, and administrative violations under the Act by any of the operating organization's staff, individuals providing services under a contractual arrangement, or volunteers, having in place and publicizing a reporting system whereby any of these individuals could report violations by others anonymously within the operating organization without fear of retribution, and having a process for ensuring the integrity of any reported data.

g. Consistent enforcement of the operating organization's standards, policies, and procedures through appropriate disciplinary mechanisms, including, as appropriate, discipline of individuals responsible for the failure to detect and report a violation to the compliance and ethics program contact identified in the operating organization's compliance and ethics program.

h. After a violation is detected, the operating organization must ensure that all reasonable steps

identified in its program are taken to respond appropriately to the violation and to prevent further similar violations, including any necessary modification to the operating organization's program to prevent and detect criminal, civil, and administrative violations under the Act.

(d) Additional required components for operating organizations with five or more facilities. In addition to all of the other requirements in paragraphs (a), (b), (c), and (e) of this section, operating organizations that operate five or more facilities must also include, at a minimum, the following components in their compliance and ethics program:

1) A mandatory annual training program on the operating organization's compliance and ethics program that meets the requirements set forth in 420-5-10-.24.

2) A designated compliance officer for whom the operating organization's compliance and ethics program is a major responsibility. This individual must report directly to the operating organization's governing body and not be subordinate to the general counsel, chief financial officer, or chief operating officer.

3) Designated compliance liaisons located at each of the operating organization's facilities.

(e) Annual review. The operating organization for each facility must review its compliance and ethics program annually and revise its program as needed to reflect changes in all applicable laws or regulations and within the operating organization and its facilities to improve its performance in deterring, reducing, and detecting violations under the Act and in promoting quality of care.

Author: Nancy L. Eady
Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.
History: **New Rule:** Published September 30, 2026; effective November 14, 2026.

420-5-10-.23 **Physical Plant and Environment.**

(1) Location.

(a) The nursing facility site shall provide space to accommodate staff and visitor parking, service access, emergency access, outdoor resident activity space, and other areas required to provide for the care and proper operation of the facility.

(b) The location and construction of all nursing facilities shall comply with local zoning, building, and fire ordinances. Evidence to this effect, signed by local fire, building, and zoning officials shall be furnished to the Alabama Department of Public Health.

(c) Nursing facilities shall be located on streets or roads which are kept passable at all times. Facilities constructed after the effective date of these rules shall be located on paved roads.

(2) Submission of Plans and Specifications.

(a) When construction is contemplated, either for new buildings, conversions, additions, or alterations to existing buildings coming within the scope of these rules, plans and specifications shall be submitted for review and approval to the Alabama Department of Public Health, in accordance with Alabama Administrative Code Rule 420-5-22, "Submission of Plans and Specifications for Healthcare Facilities."

(b) Minor alterations and remodeling which do not affect the structural integrity of the building, which do not change functional operation, which do not affect life safety, and which do not add beds over those for which the facility is licensed, need not be submitted for approval. Documentation shall be maintained for interior wall covering finishes.

(c) The renovation area of an existing nursing facility shall comply with the current requirements for new construction to the extent possible.

(3) Inspections. The Alabama Department of Public Health and its authorized representative shall have access to the site for inspection.

(4) General Requirements. The provisions of this section shall apply to all nursing facilities.

(a) Codes.

1) Nursing facilities in existence at the time of current code adoption shall comply with the code requirements for an existing building.

2) New nursing facilities, additions, or alterations shall comply with the currently adopted code requirement for a new building.

(b) Renovations within an existing facility shall comply with the applicable codes and requirements for new work.

(c) The building shall be structurally sound, free from leaks and excessive moisture, in good repair, and painted at sufficient intervals inside and out.

(d) The interior and exterior of the building shall be kept clean and orderly.

(e) Maintain an effective pest control program so that the facility is free of pests and rodents.

(f) There shall be a minimum of 20 feet of clear space measured perpendicularly between a resident bedroom window and any structure outside the window. A peripheral view of the exterior shall be provided from newly constructed bedrooms.

(g) All water is to be obtained from a public water supply. If it is impossible to connect to a public water system, the private water system shall be approved by the Alabama Department of Public Health or its appropriate designated agency.

1) Water under pressure of not less than 15 lbs. per square inch is piped within the building to all sinks, toilets, lavatories, tubs and other fixtures requiring water.

2) An adequate supply of hot water for resident and service uses is available at all times. Temperature of hot water used by residents is automatically regulated by tempering valves and shall not exceed 110 degrees Fahrenheit.

3) In the laundry, provision shall be made to increase the water temperature to 160 degrees Fahrenheit unless manufacturer documentation can be provided for the chemical being used at a lower temperature.

4) There shall be procedures established to ensure that water can be provided for all essential services in the event of loss of the normal water supply.

(h) All liquid and human waste, including floor wash water and liquid waste from refrigerators, is disposed of through trapped drains into a public sanitary sewer system in

localities where such system is available. In localities where a public sanitary sewer system is not available, liquid and human waste shall be disposed of through trapped drains and in a manner approved by the Alabama Department of Public Health or its appropriate designated agency.

1) Plumbing is so sized, installed, and maintained to carry adequate quantities of water to required locations throughout the facility, to prevent contamination of the water supply, and to properly convey sewage and liquid wastes from the establishment to the sewerage or sewage disposal system, in such a manner and so that it does not constitute a source of contamination or create an unsanitary condition or nuisance.

2) Solid, non-infectious wastes are kept in leak proof, non-absorbent containers which shall be kept covered with tight fitting lids and are disposed of in a manner approved by the Alabama Department of Public Health or its appropriate designated agency.

3) Solid wastes which are potentially infectious shall be burned on the premises in an incinerator approved by the Alabama Department of Public Health or disposed of in a manner approved by the Alabama Department of Public Health or its appropriate designated agency.

a. Lighting shall meet the following requirements:

(i) Lighting in nursing facilities shall meet the requirements as in the Illuminating Engineers Society (IES) Lighting Handbook Application volume.

(ii) Night lights shall be provided in bedrooms, hallways, toilet rooms, and bathrooms. Glowing toggle switches are acceptable in toilet rooms and bathrooms.

(i) Screens shall be provided for all operable windows.

(j) All floors shall be smooth and free from cracks and finished so that they can be easily cleaned.

(k) Walls and ceilings shall be of sound construction and maintained in good repair.

(l) Each room occupied by residents shall have a ceiling height of 8 feet or more (does not include furred area).

(m) Doors.

1) Hardware on all toilet and bathroom doors shall be operable from outside the room.

2) Bedroom doors shall not be equipped with hardware that will permit a resident to lock himself within the room.

3) Bedroom doors shall open into the bedroom.

4) To avoid danger of a resident falling and blocking the swing of a door, all doors to residents' central baths and toilets shall swing out or be double-acting and equipped with an emergency stop release.

(n) Panic hardware shall be installed on each required exit door, as well as doors to and from exit stairs.

(o) All differences in floor levels within the building shall be accomplished by steps of not less than three 6-inch risers or ramps. Either shall be equipped with handrails on both sides. (See Ramps.)

(p) The nursing facility shall be well ventilated at all times.

1) Resident bedrooms shall be ventilated in such a manner as to supply fresh air and to prevent accumulation of objectionable odors.

2) All service areas shall be ventilated as permitted by codes.

(q) All facilities shall have access to public fire hydrant protection, or the equivalent approved by the local fire department or state Fire Marshal.

(r) Handrails shall be installed on both sides of all corridors normally used by residents except for areas between doors of 24 inches or less.

(s) A corridor smoke detection system shall be provided and consist of listed devices connected to the facility's fire alarm system.

(t) When heat detectors are installed in any area, they shall be listed self-restoring type and electrically connected to the fire alarm system.

(u) Nurse Call System.

1) Existing nursing facilities shall have an electrical nurse call system at the side of each bed which will provide an initial audible signal and a visual signal on an annunciator panel at the nurses' station until deactivated. (For nursing facilities licensed after the effective date of these rules, both audible and visual signals must function until deactivated in the resident room.)

2) Nursing facilities licensed after December 26, 1988, shall have an electrical nurse call station at each bed and a light over the door to the bedrooms on the corridor.

3) An electrical nurse call system shall be provided in each resident toilet and bathroom and in addition to existing buildings and in remodeling after the effective date of these rules. This signal shall be distinct from the regular nurse call signal and turned off only at the emergency calling station.

4) On new call systems, additional visible signals shall be installed at corridor intersections or in main corridor area where rooms are recessed if patient room call lights are not visible from the nurses’ station area.

(v) Trash chutes are prohibited in nursing facilities.

(w) Elevators.

1) New facilities with residents on one or more floors above the first floor shall be equipped with at least one automatic elevator of a size sufficient to carry a resident on a stretcher.

2) If an elevator is not installed in the existing nursing facility due to exits on each floor, each floor shall have a dining room, living room, and sunroom.

3) Annual inspections shall be made of elevators by qualified inspection service personnel and inspection documents maintained in the facility.

(x) Sufficient general storage space shall be provided for the storage of equipment, supplies, etc., to prevent the need for storage in hallways or other non-storage areas of the facility and be adequately ventilated.

(y) Facilities for Physically Handicapped.

1) Necessary accommodations shall be made to meet the needs of persons with semi-ambulatory disabilities, sight and hearing disabilities, disabilities of coordination, as well as other disabilities in accordance with the American National Standard Institute (ANSI), A117.1 - 1992, *American National Standard for Buildings and Facilities - Providing Accessibility and Usability for Physically Handicapped People*.

2) In nursing facilities existing prior to these rules, provisions shall be made to accommodate the handicapped.

(z) Ramps and inclines, where installed, shall not exceed a rise of 1 foot in 12 feet of run, shall be finished with a non-slip surface and provided with handrails on both sides.

(aa) Open fire escapes are permitted in institutions licensed prior to October 9, 1957, provided such fire escapes meet the following requirements:

1) Must be of non-combustible material.

2) Must have a railing or guard at least 4 feet high on each unenclosed side.

3) Wall openings adjacent to fire escapes are protected with fire resistive doors and protected windows.

4) Doors leading to fire escapes shall open in the direction of exit and be provided with panic hardware.

(bb) Generator Power.

1) Nursing facilities and additions to nursing facilities shall have an emergency generator and supporting equipment that complies with and supports the

standards set out for nursing homes at Article 517.41 of the National Electrical Code.

2) Task illumination shall be provided as part of the essential power system as set for nursing homes at Article 517.41 of the National Electrical Code, and the following areas shall be included:

a. Recreational Areas such as Living Rooms, Dining Rooms, Day Rooms, and Chapels: in facilities built and renovated after December 28, 1988.

b. Electrical Equipment Room, Generator Room and Boiler Room: in facilities built and renovated after December 28, 1988. Electricity may be switch controlled in these rooms.

c. Fire sprinkler pump system, if provided, and sprinkler riser room lighting.

(cc) Mechanical, electrical, plumbing, heating, air conditioning, and water systems shall be installed to meet the requirements of local codes and ordinances and the applicable regulations of the State Committee of Public Health at the time of construction.

(dd) All essential mechanical, electrical, and resident care equipment shall be maintained in safe operating condition. The facility shall establish a written preventive maintenance program to ensure that all equipment is operative.

(ee) The use of portable heaters of any kind is prohibited except during emergency situations caused by severe weather that disables the normal heating system.

(ff) When life support systems are used, electrical service shall comply with currently adopted codes and shall be on the required branch of the essential power system.

(gg) Fire alarm systems shall be tested monthly by an alarm initiating device to verify proper functioning of the alarm system. Documentation of the testing shall be maintained, noting the proper functioning of notification devices, releasing of door holders and locks, operation of smoke dampers, and air handling unit shutdown.

(5) New Construction Requirements.

(a) The provisions of this section, in addition to the provisions of Chapter 420-5-10-.18(4), (6) & (7), shall apply to all new nursing facilities or additions or renovations to nursing facilities initially licensed after the effective date of these rules or to any existing nursing facility which meets or can readily be improved to meet these requirements.

(b) Facilities initially licensed, as well as additions or alterations to existing facilities, constructed after the effective date of these rules shall be classified as healthcare occupancy, and shall comply, at the time of plan approval, with codes and standards adopted by the State Committee of Public Health. See Alabama Administrative Code, Rule 420-5-22, for listing of adopted codes and standards.

(c) Doors.

1) All doors in line of exit travel shall be hinged and shall swing in the line of travel.

2) All exit doors serving residents including doors to stairs shall be at a minimum 44 inches wide.

3) Doors to toilets used by residents in additions or new facilities shall be at least 34 inches wide.

4) Where rated doors are required by code, a permanent label from an independent testing laboratory shall be attached to the door.

(d) Corridors in resident areas shall be at least 8 feet wide, except as permitted by code.

(e) Exit passageways other than corridors in resident areas shall not be less than 4 feet wide.

(f) Corridors and passageways shall be unobstructed and shall not lead through any room or space used for a purpose that may obstruct free passage.

(g) Handrails shall be installed on both sides of all corridors normally used by residents except between doors in spaces 24 inches or less.

1) The handrails shall have a circular grip, a clearance of 1½ inches from the wall and be mounted 30-34 inches from the floor to the top of the rail.

2) Handrails shall return to the wall at all terminations.

3) Handrails may be omitted where service corridors are not part of a required exit from resident areas, the corridor is not a path of circulation from one resident area to another and cross corridor doors are installed. These doors shall separate resident corridors from service corridors and shall normally remain closed.

(h) Each tub or shower shall be in an individual room or enclosure with space for the private use of the bathing fixture, for drying and dressing. A separate toilet shall be available for each central bathing area without requiring entry into the general corridor.

(i) If a facility chooses to admit or retain residents requiring life support equipment, essential electrical distribution systems shall conform to a Type II System as required in *NFPA 99*. As a minimum, life support systems shall be provided in 10 percent of the bedrooms and receptacles every 50 feet on alternating walls in the corridor.

(6) Rooms, Spaces, and Equipment - New and Existing Facilities.

(a) Nursing Unit. A nursing unit consists of the number of beds served from one nurses' station and includes all of the necessary support areas required to provide care to the residents.

1) Each nursing unit shall have:

a. Nurses' station.

b. Clean utility room.

c. Medicine preparation room.

d. Soiled utility room or soiled holding room.

e. Clean linen storage room.

f. Wheelchair and stretcher storage areas.

g. Janitor's closet with mop sink or floor receptor and storage shelving.

h. Nourishment room.

i. Staff restroom.

2) On a nursing unit, no residents' bedroom door shall be more than 150 feet from the nurses' station.

(b) Bedrooms.

1) All bedrooms shall have window(s) with the windowsills not more than 3 feet above the floor. Windows shall not be below grade.

2) The window area shall not be less than one-tenth of the floor area. Windows do not need to be operable.

3) Residents' bedrooms shall be located so as to minimize the entrance of odors, noise, and other nuisances. Residents' bedrooms shall be directly accessible from the main corridor of the nursing unit. Existing resident bedrooms may be accessible from any public space other than the dining room. In no case shall a resident's bedroom be used for access to another resident's room.

4) The capacity of any new room shall not exceed two residents, and the capacity of existing rooms shall not exceed four residents.

5) The minimum floor area of bedrooms, exclusive of toilets, closets, wardrobes, alcoves, or vestibules in facilities and additions to existing facilities constructed after October 20, 1967, shall be as follows:

a. Private room: 100 Square Feet.

b. Multi-Resident room: 80 Square feet per resident.

6) There shall be sufficient space to permit nursing procedures to be performed and to permit the placing of beds at least 3 feet apart, and 3 feet from the wall at the foot of the bed. Sides of beds shall maintain a minimum clearance of 12 inches from electrical outlets in walls, unless electrical outlet and plug protection is maintained.

(c) Provisions for privacy. Each multi-resident room shall have permanently installed cubicle curtain tracks to permit enclosing each bed with curtains to allow for the privacy of

each resident without obstructing the passage of other residents either to the corridor, closet, or to the toilet/ lavatory adjacent to the resident room.

(d) Accommodations for Residents. The minimum accommodations for residents shall include the following:

1) Residents shall be provided with a standard or adjustable bed.

2) Chair and bedside table.

3) Storage space for clothing, toilet articles, and personal belongings.

4) Bedside electrical call system for summoning aid.

5) Waste paper receptacle.

6) A headwall bed light must be mounted so that it is operable by the resident from the bed.

7) Nursing facilities or additions to nursing facilities constructed after November 16, 1988, shall provide a hand washing lavatory in each bedroom. It may be omitted from bedroom when a lavatory is provided in an adjoining toilet or bathroom.

(e) Isolation Room.

1) Isolation rooms shall be provided at the rate of not less than one private bedroom per 50 beds or major fraction thereof for the isolation of residents suffering from infectious diseases as defined by the Centers for Disease Control and Prevention (CDC). The bedroom shall meet all of the requirements for bedrooms as previously stated in these regulations. Isolation bedrooms may be used to provide for the special care of residents who develop acute illnesses, have personality problems, or residents in terminal phases of illness. If central heating/cooling is provided, the air from the room shall be exhausted directly to the outside.

2) Isolation rooms in nursing facilities shall have a lavatory within the room or within a private toilet.

(f) Nurses' Station. The nurses' station for each nursing unit shall include as a minimum the following:

1) Annunciator board for receiving residents' calls.

2) Cabinet space.

3) Storage space for current residents' charts.

4) Working space and accommodations for recording and charting purposes by facility staff.

5) Medicine preparation room. The room at each nurses' station shall have, as a minimum, 80 square feet of floor space with an additional square foot for each bed in excess of 50 beds per unit. This requirement pertains to any construction or renovation after November 16, 1988. If medication carts are utilized, sufficient storage space for the carts and over-the-counter stock medications must be provided in lieu of a medication preparation room.

(g) Utility Rooms. In new nursing facilities and in additions to existing nursing facilities after December 26, 1988, a separate clean and soiled utility room shall be provided for each nursing unit.

1) The clean utility room shall contain as a minimum:

a. Wall and base cabinets.

b. Counter space.

c. Countertop sink.

d. Paper towel dispenser.

e. Soap dispenser.

2) The soiled utility room shall contain at a minimum:

a. Paper towel and soap dispensers.

b. Shelves.

c. Cabinets for storage of poisonous substances; i.e., cleaning supplies, urine test products, etc.

d. Countertop.

e. Large single compartment counter or freestanding service sink for chemical sterilization of bedpans, urinals and commode pails.

f. Wall mounted or countertop hand washing lavatory, separate from the service sink.

g. Soiled linen hamper(s).

h. Clinical sink or equivalent flushing-rim fixture unless toilet with bedpan lug and bedpan washer are provided in adjoining toilets to all bedrooms in the nursing unit.

3) In nursing facilities, each nursing unit shall have a separate clean and soiled utility room.

(h) Toilet and Bathing Facilities.

1) For all resident bedrooms which do not have adjoining toilet and bath facilities, plumbing fixtures shall be provided within the nursing unit, according to the following ratio:

a. Bathtubs or showers, 1 per 25.

b. Beds lavatories, 1 per 6 Beds.

c. Toilets (water closets), 1 per 6 Beds.

2) Non-skid mats, or equivalent, and grab bars shall be provided at tubs and showers. Grab handles on soap dishes are not acceptable for grab bars.

3) Grab bars shall be provided at each water closet.

(i) Nourishment Room.

1) Nursing units in facilities and additions to facilities constructed after August 23, 1996, shall have a nourishment room containing a work counter, refrigerator, storage cabinet, and a sink for serving nourishments between meals. Ice for residents' consumption shall be provided by icemaker units. The nourishment room shall include space for trays and dishes used in non-scheduled meal service.

2) Existing facilities shall provide a nourishment room in accordance with the above paragraph when the nursing unit is remodeled or expanded.

3) Nourishment room shall be separated from corridor by wall and door.

(j) Dining/Recreation/Sitting. In new nursing facilities or additions to nursing facilities, there shall be resident dining, and recreation/sitting areas in accordance with the following:

1) The total area set aside for these purposes shall be at least 20 square feet per bed for new facilities and for expanded facilities.

a. Dining Room. The dining room shall be capable of seating 50 percent of the bed capacity.

b. Recreation/Sitting Area. These areas shall not include exterior porches and lobby/waiting room.

2) As a minimum, the facility shall include two separate recreation/sitting areas and a dining area.

3) Each nursing unit shall contain at least one recreation/sitting area.

4) A minimum of at least one porch and/or glass enclosed sun parlor shall be provided for the use of residents.

(k) Physical Therapy. Physical therapy areas, if provided, shall be in a specifically designated area and shall include equipment and areas as needed to meet specific resident requirements and shall also include storage space for linens, supplies, and equipment, a countertop or wall hung handwash lavatory, and a service sink in a counter or freestanding.

(l) Laundry.

1) The existing laundry room, or storage and counting area shall be located so that soiled linens are not carried through the food service area.

2) Laundries built, renovated, or added to after August 23, 1996, shall provide the following rooms and shall comply with the additional requirements:

a. Adequate holding and sorting room for control and distribution of soiled linen. Discharge from soiled linen chutes may be received within this room or in a separate room (soiled linen room).

b. The laundry shall be vented so that odors do not enter the nursing facility. Air shall not be recirculated into a heating or cooling system serving other areas of the nursing facility.

c. Corridors shall not be used to store or hold soiled linen or clean linen carts at any time of the day. Adequate space shall be provided in the soiled linen room and laundry processing room to prevent this.

(m) Beauty/Barber Shop. Nursing facilities or additions to nursing facilities licensed after November 16, 1988, shall have space and equipment for resident hair care and grooming. The room shall open to a corridor.

(n) Administration. The administrative department and services shall be located in a specifically designated area and shall include the following:

1) Administrator's office.

2) Business office.

3) Public lobby or waiting room.

4) Public toilets.

5) For facilities constructed after August 23, 1996, or when existing lobbies are renovated, handicapped public toilets accessible from the lobby/waiting room shall be provided.

(o) Support Offices. Nursing facilities or additions to nursing facilities constructed after August 23, 1996, shall provide office space for all support staff.

(p) Nursing facilities and additions to nursing facilities constructed after August 23, 1996, shall provide adequate closet or locker storage space for staff's work-related personal items.

(q) Maintenance. Each facility shall provide facilities/ room(s) to accommodate routine maintenance appropriate to the needs.

(7) Dietary (applies to all facilities).

(a) Food service facilities shall be located in a designated area and shall include the following rooms and spaces: food production, food service, food storage, dishwashing, dining room, dietary manager's office, water heating equipment, and janitor closet (mops, brooms, mop sink) in all facilities built after August 23, 1996.

(b) The dietetic service area shall be of such size and dimensions as to permit orderly and sanitary handling and processing of food. Avoid overcrowding and congestion of operations.

(c) Hand washing facilities. Hand-washing facilities shall be provided in all food production and serving areas. Sinks shall be equipped with a soap dispenser and adequate supply of soap, disposable towels, and hot and cold running water. The use of a common towel is prohibited. Hands must not be washed in sinks where food is prepared.

(d) Refrigeration. Where separate refrigeration can be provided, temperatures for storing perishable foods are: 32 to 38 degrees Fahrenheit for meats, 40 degrees Fahrenheit for dairy products, 45 to 50 degrees Fahrenheit for fruits and vegetables. If it is impractical to provide separate refrigeration, the temperature shall be maintained at 38 to 40 degrees Fahrenheit at all times. Frozen food shall be maintained at 0 degrees Fahrenheit or below.

(e) Dish and Utensils Washing, Disinfection and Storage. Facilities shall comply with current requirements of the Rules of Alabama State Committee of Public Health for Food Establishment Sanitation, Alabama Administrative Code Chapter 420-3-22-.15 "Equipment and Utensil Cleaning and Sanitation," and Chapter 420-3-22-.16, "Equipment and Utensil Storage."

Author: Tony Dunklin
Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.
History: **New Rule:** Published September 30, 2026; effective November 14, 2026.

420-5-10-.24 Training Requirements.

(1) A facility must develop, implement, and maintain an effective training program for all new and existing staff; individuals providing services under a contractual arrangement; and volunteers, consistent with their expected roles. A facility must determine the amount and types of training necessary based on a facility assessment. Training topics must include but are not limited to:

(a) Communication. A facility must include effective communications as mandatory training for direct care staff.

(b) Residents' rights and facility responsibilities. A facility must ensure that staff members are educated on the rights of the residents and the responsibilities of a facility to properly care for its residents.

(c) Abuse, neglect, and exploitation. In addition to freedom from abuse, neglect, and exploitation, facilities must also provide training to their staff that at a minimum educates staff on:

1) Activities that constitute abuse, neglect, exploitation, and misappropriation of resident property.

2) Procedures for reporting incidents of abuse, neglect, exploitation, or the misappropriation of resident property.

3) Dementia management and resident abuse prevention.

(d) QAPI. A facility must include as part of its QAPI Program mandatory training that outlines and informs staff of the elements and goals of the facility's QAPI Program.

(2) Infection Control. A facility must include as part of its infection prevention and control program mandatory training that includes the written standards, policies, and procedures for the program as described at 420-5-10-.21.

(3) Compliance and Ethics. The operating organization for each facility must include as part of its compliance and ethics program:

(a) An effective way to communicate the program's standards, policies, and procedures through a training program or in another practical manner which explains the requirements under the program.

(b) Annual training if the operating organization operates five or more facilities.

(4) Required In-service Training for Nurse Aides. In-service training must:

(a) Be sufficient to ensure the continuing competence of nurse aides but must be no less than 12 hours per year.

(b) Include dementia management training and resident abuse prevention training.

(c) Address areas of weakness as determined in nurse aides' performance reviews and facility assessment and may address the special needs of residents as determined by the facility staff.

(d) For nurse aides providing services to individuals with cognitive impairments, also address the care of the cognitively impaired.

(5) Training for Feeding Assistants. A facility must not use any individual working in the facility as a paid feeding assistant unless that individual has successfully completed a state-approved training program for feeding assistants.

(6) Behavioral Health. A facility must provide behavioral health training as determined by the facility assessment.

Author: Nancy L. Eady
Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq.
History: **New Rule:** Published September 30, 2026; effective November 14, 2026.