**ALABAMA STATE COMMITTEE OF PUBLIC HEALTH**
**ALABAMA DEPARTMENT OF PUBLIC HEALTH**
**ADMINISTRATIVE CODE**

# CHAPTER 420-5-17
# HOSPICES

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## 420-5-17-.01 Definitions.

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

(a) "Aide" means an individual who provides personal care services for hospice patients and their families as set forth under 420-5-17-.13.

(b) "Applicant" means a person or public agency legally responsible for operation of the hospice.

(c) "Attending Physician" means the physician identified by the hospice patient or the hospice patient's family as having primary responsibility for the hospice patient's medical care.

(d) "Biological" means a drug with a component containing a virus, therapeutic serum, toxin, antitoxin, or analogous product applicable to the prevention, treatment, or cure of diseases or injury in man.

(e) "Qualified Dietitian" means a person who graduated from an approved school and is licensed in the State of Alabama in accordance with Title 34, Chapter 34A Code of Ala. 1975.

(f) "Dietary Manager" is a person who 1) is a qualified dietitian, or 2) is a graduate of a dietetic technician program approved by the American Dietetic Association, or 3) is a graduate of a dietary managers training program, approved by the Dietary Managers Association.

(g) "Governing Body" means the entity that has ultimate responsibility and authority for the overall operation of a Hospice Care Program, as set forth under 420-5-17-.05.

(h) "Hospice Care Program" or "program" means a coordinated program of home, outpatient, and inpatient care and services including the coordination of the services listed below to hospice patients and families, through a medically directed interdisciplinary team, under interdisciplinary plans of care established pursuant to Section 22-21-20 of the Code of Ala. 1975, in order to meet the physical, psychological, social, spiritual, and other special needs that are experienced during the final stages of illness, dying, and bereavement:

1. Nursing care by or under the supervision of a registered nurse.

2. Medical social services by a social worker under the direction of a physician.

3. Services of an aide.

4. Medical supplies, including drugs and biologicals, and the use of medical appliances.

5. Physician's services.

6. Short-term inpatient care, including both palliative and respite care and procedures.

7. Counseling for hospice patients and hospice patients' families.

8. Services of volunteers under the direction of the provider of the hospice care program.

9. Bereavement services for hospice patients' families.

(i) "Hospice Patient" or "Patient" means a patient who has been diagnosed as terminally ill, has a limited life expectancy, and has voluntarily requested and is receiving palliative care from a person or agency licensed to provide a hospice care program under Chapter 17.

(j) "Hospice Patient's Family" or "Family" means a hospice patient's immediate family members, including a spouse, brother, sister, child, or parent, and any other relative or individual who has significant personal ties to the patient and who is designated as a member of the patient's family by mutual agreement of the patient, the relative or individual, and the hospice program's interdisciplinary team.

(k) "Inhome Hospice" means a facility that provides hospice care services in a patient's home.

(l) "Inpatient Hospice" means a facility that either is operated by or under contract with a hospice care program for the purpose of providing inpatient care to the program's patients.

(m) "Interdisciplinary Plan of Care" or "Plan of Care" means the interdisciplinary plan for care of a hospice patient and his or her family.

(n) "Interdisciplinary Team" means a working unit composed of professional and lay persons that includes at least a physician, a registered nurse, a social worker, a chaplain, member of the clergy or a counselor, and a volunteer coordinator.

(o) "Legend Drug" means a prescription drug.

(p) "Licensed Practical Nurse" means a person ,licensed in accordance with Code of Ala. 1975 Section 34-21-22.

(q) "Manager" means a person delegated the responsibility for the interpretation, implementation, and proper application of policies and programs established by the governing authority. This responsibility shall be accompanied by corresponding authority.

(r) "May" indicates permission.

(s) "Nurse" means registered nurse or licensed practical nurse.

(t) "OTC Drug" means a non-prescription drug.

(u) "Palliative Care" means treatment directed at controlling pain, relieving other symptoms, and focusing on the special needs of a hospice patient and the hospice patient's family as they experience the stress of the dying process, rather than treatment aimed at investigation and intervention for the purpose of cure or prolongation of life.

(v) "Person" means an individual, corporation, business trust, estate, trust, public agency, partnership, and/or association.

(w) "Pharmacist" means a person graduated from an approved school of pharmacy currently licensed to practice pharmacy in Alabama under the provisions of Title 34, Chapter 23 of Code of Ala. 1975.

(x) "Physician" means a person currently licensed to practice medicine in accordance with Title 34, Chapter 24, Article 8 of Code of Ala. 1975.

(y) "Respite Care" means hospice care program services provided by the program to give temporary relief to a hospice patient's family or other caregivers.

(z) "Registered Nurse" means a person licensed in accordance with Code of Ala. 1975, Section 34-21-21.

(aa) "Shall" indicates mandatory requirements.

(bb) "Social Worker" means a person who holds at least a bachelors degree in social work from an accredited school of social work, and is currently licensed by the State of Alabama or supervised in accordance with Title 34, Chapter 30 of Code of.Ala. 1975

(cc) "Volunteer" means a lay or professional person who offers and provides his or her services to a hospice care program without compensation.

(dd) "Volunteer Coordinator" means a lay or professional person who is responsible for assigning volunteers to patients, families, and other duties, including recruiting, training, retaining volunteers and evaluating the volunteer program.

**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.
**History:** **New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective

July 19, 2000. **Amended:** Filed January 15, 2003; effective February 19, 2003.

**420-5-17-.02 Licensing And Administrative Procedures.**

(1) **Legal Authority for Adoption of Regulations.** Pursuant to the authority granted by Code of Ala. 1975, Sections 22-21-20 to Sections 22-21-33, and in accordance with the *Alabama Administrative Procedures Act*, Code of Ala. 1975, Sections 41-22-1 to Section 41-22-27, the State Board of Health does hereby adopt and promulgate rules governing all nursing or hospices in Alabama except those exempt by law from licensure.

(2) **Type 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 Board of Health after the board has determined that the hospice is in substantial compliance with rules herein adopted.

(b) Probational license. The State Board of 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 hospice no longer substantially complies with the rules adopted herein. However, the Board may issue a probational license only after determining that the health and safety of patients are adequately protected despite non-compliance, and that the facility has submitted an adequate written plan to correct the non-compliance in a timely manner. Maximum length of time for probational status is one year.

(3) **Application and Fee.**

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

(b) Each application for licensed shall be accompanied by a fee as mandated by statute. No fee shall be refunded. Fees shall be paid by cash, check or money order made payable to the Alabama Department of Public Health.

(4) **Licensing.**

(a) Issue of License. The license document issued by the State Board of Health shall set forth the name and location of the hospice, the type of facility, the area of operation, the bed capacity, if applicable, and the type of license (regular or probational).

(b) Separate licenses. A separate license shall be required for each hospice when more than one hospice is operated under the same management, at a different location, and has a separate professional staff and patient load.

(c) Name of hospice. Every hospice must 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 Board specifying the name to be discontinued as well as the new name.

(d) Location of hospice. A hospice must be physically located within the State of Alabama.

(5) **Basis for Denial of License.**

(a) The State Board of Health may deny a license to any corporation, partnership or individual making application to own or operate any hospice if said corporation, partnership or individual:

1. Has falsified any information or record required by the application for license.

2. Has been found by a court or by a state or federal agency after the provision of appropriate due process to have committed abuse or neglect of any individual or to have misappropriated the property of a patient or resident of a health care facility.

3. Has been convicted of fraud in this or any state, or in any federal jurisdiction within the past five years.

4. Has previously been the subject of license revocation proceedings and does not demonstrate a present ability and willingness to fully comply with State Board of Health rules, or

5. Is unable to demonstrate sufficient ability and resources to fully comply with State Board of Health rules.

(b) Basis for license revocation. The State Board of Health may revoke a license to operate a hospice if the owner and/or operator of said facility:

1. Violates any of the provisions of these rules and regulations.

2. Permits, aids or abets the commission of any illegal act in such hospice, or

3. Engages in conduct or practices deemed by the State Board of Health to be detrimental to the welfare of the patients of such hospice.

(6) **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 Alabama Administrative for contested case proceedings under the Procedures Act, Code of Ala. 1975, Section 41-22-17, and Chapter Alabama Administrative Code420-1-3 of the .

(7) **Research Projects.** Any licensee who is, or contemplates being, engaged in a bona fide research program which may be in conflict with one or more specific provisions of these rules may make application for waiver of the specific provisions in conflict. Application for waiver shall be made in writing to the Licensure Advisory Board who shall, upon completion of its investigation, send its findings, conclusions, and recommendations to the State Board of Health for final action.

(8) **Reissuance of License.** The following changes in the status of the hospice will require issuance of a new license, upon application and payment of a licensing fee.

(a) Change in hospice 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 hospice's legal title.

2. Lease of the entire hospice'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. Two or more corporations merge and the originally licensed corporation does not survive.

7. Corporations consolidate.

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

(b) Increase in bed capacity.

(c) Changes in type of care offered (home care to inpatient).

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

1. Change in facility name.

2. Relocation of the hospice.

3. Change in service area.

(e) The governing authority shall file with the State Board of 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.

(9) **Compliance Exceptions.** At its discretion, the State Board of 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 Board. The exceptions or modifications shall be based on hardship, impracticability, or economic infeasibility in complying with the rules. The hospice'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.

(10) **Compliance with State and Local Laws.**

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

(b) Compliance with other laws. The hospice shall be in compliance with state and local laws relating to fire and safety, sanitation, communicable and reportable diseases, certificate of need, if applicable, and other relevant health and safety requirements.

(11) **Inspections.** Failure or refusal to submit to a survey will result in initiation of license revocation proceedings. Findings noted during any survey shall be corrected by execution of a plan of correction. The plan of correction shall be succinctly written to address identified problems in a timely manner not to exceed 60 days or such other time as may be required by the director.
**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.

**History: New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000. **Amended:** Filed January 15, 2003; effective February 19, 2003.

**420-5-17-.03 General Requirements For Hospice Care Programs After Licensure.**

(1) Any person licensed to provide a hospice care program shall:

(a) Ensure the provision of the core services of nursing, social work, physician, pastoral or other counseling and volunteer services. The majority of these services shall be provided directly by hospice employees. Persons providing these services directly or by contract shall be responsible to, and function as part of, the interdisciplinary team. A planned and continuous hospice care program, the medical components of which shall be under the direction of a physician, shall be provided.

(b) Ensure that care is available twenty-four hours a day and seven days a week.

(c) Establish a written interdisciplinary plan of care for each hospice patient and family that:

1. Is coordinated by one designated individual who shall ensure that all components of the plan of care are addressed and implemented.

2. Addresses maintenance of patient-family participation in decision making.

3. Is periodically reviewed by the patient's attending physician and by the patient's interdisciplinary team.

4. Ensures that an interdisciplinary team provides or supervises the provision of care and establishes the policies governing the provision of care.

5. Provides bereavement care for hospice patient's family for at least one year, or until appropriately discharged from the bereavement program.

6. Continues care regardless of a hospice patient's ability to pay for the care.

7. Maintains central clinical records on all hospice patients under its care.

8. Provides care in individual's homes and provides or coordinates care on an inpatient basis. Not more than 50% of the home care days shall be provided to residents of nursing homes.

(2) Each licensed hospice care program shall notify the Alabama Department of Public Health, in writing, of any of the following:

(a) Any change that would render the information submitted in the license application inaccurate. Said information must be submitted at least twenty-one days prior to the effective date of the change.

(b) Any intent to cease operation of the program. Such notification shall be submitted at least 60 days prior to ceasing operation, and shall include a plan for assuring continuity of care for the program's patients and their families after the cessation.

(3) **Vital Statistics Reports.** A record shall be kept of all births, deaths, and stillbirths that occur within the inpatient hospice. By the fifth day of each month, the manager shall make a report of such births, deaths, and stillbirths for the preceding month on such forms as the State Board of Health shall provide to the county health officer, or in counties without a county health officer, to the State Registrar. This report shall be in addition to the official birth, death, and stillbirth certificates. If there are no births, deaths, or stillbirths in any month, a report shall be made stating that fact to the county health officer.

(4) **Unusual Occurrences.** Occurrences such as catastrophes and unusual occurrences which threaten the welfare, safety of health of patients, personnel, or visitors shall be reported by the hospice within 24 hours either by telephone (and confirmed in writing) or by facsimile to the Alabama Department of Public Health and other agencies/authorities as required. These occurrences include, but are not limited to, suspected cases of patient abuse, life threatening burns, fires, deaths under unusual circumstances, and outbreaks of infectious reportable diseases.

(5) Patient Transport. If a patient is unable to ride in an upright position or if such patient's condition is such that he or she needs observation or treatment by Emergency Medical Services personnel, or if the patient requires transportation on a stretcher, gurney or cot, the facility shall arrange or request transportation services only from providers who are ambulance service operators licensed by the Alabama State Board of Health. If such patient is being transported to or from a health care facility in another state, transportation services may be arranged with a transport provider licensed as an ambulance service operator in that state. For the purposes of this rule, and upright position means no more than 20 degrees from vertical.
**Author:** Rick Harris

**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq. **History: New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000. **Amended:** Filed June 23, 2004; effective July 28, 2004.

**420-5-17-.04 Patients' Rights.**

(1) **Policies and Procedures** regarding the rights and responsibilities of patients shall be written, implemented, and made available to patients, to any guardians, to any sponsor, next-of-kin, sponsoring agency (or agencies), representative payees, and to the public. Patients and sponsors will be informed on patient rights and given the toll-free complaint telephone number for the Alabama Department of Public Health, both verbally and in writing, at the time of admission. This shall be documented in the patient's record. The staff shall be trained and involved in the implementation of these policies and procedures. Posters clearly stating patient rights will be visible in key locations in the hospice. These posters will also include the toll-free complaint telephone number. These patients' rights polices and procedures ensure that, at least, each patient admitted to the hospice:

(a) Has the right to be fully informed, as evidenced by the patient's written acknowledgment prior to or at the time of admission and during stay, of these rights and of all rules and regulations governing patient conduct and responsibilities.

(b) Be fully informed of services available and of related charges including any charges for services not covered by third party payers.

(c) Be fully informed by a physician of his or her medical condition unless medically contraindicated (as documented by a physician in the medical record); and, is afforded the opportunity to participate in the planning of his or her medical treatment and the right to refuse treatment or participation in experimental research.

(d) Is not to be transferred or discharged except when transfer or discharge is necessary for the patient's welfare and the patient's needs can no longer be met or when the patient presents a direct threat to the health or safety of others, for medical reasons, or for his or her welfare or that of other patients, or for nonpayment for his or her stay. The hospice shall discuss discharge plans with the patient or their legal representative, the hospice Medical Director and/ or attending physician and the appropriate interdisciplinary team members prior to the discharge. The hospice shall

identify post hospice care needs and provide adequate discharge planning. The hospice patient or their legal representative shall be provided written discharge instructions on medication management and procurement, durable medical equipment, availability of community resources and other identified needs at the time of discharge. The required discharge forms must be completed timely. Such actions shall be documented in the medical record.

(e) Is encouraged and assisted throughout the period of stay to exercise rights as a patient and as a citizen, and to this end may voice grievances and recommend changes in policies and services to hospice staff and/or to outside representative of his or her choice without being subjected to restraint, interference, coercion, discrimination, or reprisal.

(f) May manage his or her personal financial affairs. Should a patient delegate responsibility to the hospice for the management of his or her financial affairs, said delegation shall be in writing, and the hospice shall provide the patient with at least a quarterly accounting of financial transactions made on his or her behalf.

(g) Is free from mental and physical abuse; and free from chemical and (except in emergencies) physical restraints, except as authorized in writing by a physician for a specified and limited period of time, or when necessary to protect the patient from injury to self or to others.

(h) Is assured confidential treatment of personal and medical records, and may approve or refuse their release to any individual outside the hospice except in case of transfer to another health care institution or as required by law or third-party payment contract.

(i) Is treated with consideration, respect, and with full recognition of his or her dignity in caring for personal needs.

(j) Is not required to perform services for the hospice that are not included for therapeutic purposes in the plan of care. The following apply to inpatient hospices:

1. May associate and communicate privately with persons of his or her choice, and send and receive personal mail unopened.

2. May meet with and participate in the activities of social, religious, and community groups at his or her discretion.

3. May retain and use personal clothing and possessions as space permits, unless to do so would infringe upon rights of other patients.

(k) If married, is assured privacy for visits by his/her spouse. If both are inpatients in the hospice, they are permitted to share a room. The following apply to all hospices:

(2) **Responsible Party (Parties).**

(a) In the case of a patient adjudged incompetent under the laws of a state by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under state law to act on the resident's behalf.

(b) In the case of a patient who has not been adjudged incompetent by the state court, any legal surrogate designated in accordance with state law may exercise the resident's rights to the extent provided by state law.

(3) **Notification of Changes in Patient Status.** The hospice shall have appropriate written policies and procedures relating to notification of the patient's attending physician and other responsible persons in the event of accident involving the patient, or other significant change in the patient's physical, mental or emotional status. Except in medical emergency, a patient shall not be transferred or discharged, nor treatment altered radically, without consultation with the patient or, if the patient is incompetent, without prior consultation with next-of-kin or sponsor.

**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.
**History: New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000. **Amended:** Filed July 22, 2013; effective August 26, 2013.

**420-5-17-.05 Governing Body.**

(1) The overall conduct and operation of the hospice care program, including the quality of care and the provision of services, shall be the full legal responsibility of a clearly defined, organized governing body which shall perform the following functions:

(a) Establish and review policies for the management, operation, and evaluation of the hospice care program, including establishing qualifications of employees and independent contractors.

(b) Arrange for a physician to serve as medical director for the hospice care program.

(c) Appoint in writing an individual who is responsible for the day to day management of the hospice program.

(2) There must be an individual authorized in writing to act for the manager during the manager's absences.

(a) The manager serves as liaison between the governing body and the professional staff, consultants, and other agencies and organizations.

(b) The manager acts upon recommendations of the hospice's committees, department heads and consultants.

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

(3) **Financial.** The accounting method and procedures used shall be sufficient to permit an annual audit, accurate determination of the cost of operation, and the cost per patient per day.
**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.
**History: New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000.

**420-5-17-.06 Personnel.**

Each hospice care program shall utilize personnel to provide services that have appropriate training and qualifications for the services that they provide. Any staff member, including a volunteer, who functions in a professional capacity shall meet the standards applicable to that profession, including but not limited to, possessing applicable license, registration, or certification, if required by law, and practicing within the applicable scope of practice.

(1) The hospice care program shall provide each staff member, including volunteer and contracted staff members, with a written job description delineating his or her responsibilities. The program shall assure that all staff members, including volunteers, provide services to hospice patients and their families in compliance with all of the following standards:

(a) Services are provided in accordance with the patient's plans of care.

(b) Services are provided in accordance with the policies and procedures developed by the interdisciplinary team or teams.

(c) Services are provided in accordance with current and accepted standards of practice.

(d) Services are provided by staff members who comply with the program's employee health policies.

(e) All services are documented in the patient's central clinical record.

(2) Each hospice care program shall have a policy which provides for orientation and ongoing education programs for its personnel, including volunteers that is consistent with acceptable standards of hospice practice which emphasizes:

(a) The hospice care programs' goals and services.

(b) Confidentiality and the protection of patient and family rights.

(c) Procedures for responding to medical emergencies or deaths.

(d) The physiological and psychological aspects of terminal illness.

(e) Family dynamics, coping mechanisms, and psychosocial issues surrounding terminal illness, death, and bereavement.

(f) Safety policies and procedures.

(g) General communication skills.

(h) Licensed nurses, in addition, shall be trained in pain and symptom management.

(i) Documentation of orientation and ongoing education shall be maintained in the personnel or volunteer file.

(3) Each hospice care program shall evaluate the performance of each staff member at least annually.

**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.
**History:** **New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000.

**420-5-17-.07 Medical Director.**

The medical director of a hospice care program shall be a physician licensed to practice medicine in the State of Alabama and shall have overall responsibility for the medical component of the program.
**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.
**History:** **New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000. **Amended:** Filed January 15, 2003; effective February 19, 2003.

**420-5-17-.08 Interdisciplinary Team And Interdisciplinary Plan Of Care.**

Each hospice care program shall have an interdisciplinary team or teams that provides or supervises the provision of hospice care and services.

(1) The interdisciplinary team or teams shall perform the following functions:

(a) Establish policies and procedures governing the provision of care.

(b) Establish an interdisciplinary plan of care for each patient and family.

(c) Coordinate and provide or supervise the provision of all components of each interdisciplinary plan of care. At least one individual shall be designated to ensure all of the following:

1. There is ongoing assessment of the patient's and family's needs.

2. All components of the plan of care are addressed by the interdisciplinary team.

3. The plan of care is implemented in accordance with its terms.

4. Review the interdisciplinary plan of care at least every 30 days.

5. Encourage and foster active involvement of the patient and family in the development and implementation of the interdisciplinary plan of care.

6. Evaluate the care and services provided and monitor the continuity of care across all settings for the hospice care program's patients and their families.

(2) A hospice care program shall ensure that each patient's attending physician reviews the patient's plan of care at least every 90 days.

**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.
**History: New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000.

**420-5-17-.09 Contracted Services.**

A provider of a hospice care program may arrange for another person or public agency to furnish a component or components of the hospice care program pursuant to a written contract.

(1) Any contract executed under the paragraph above, including a contract to which paragraph (2) of this rule applies, shall be legally binding on both parties and shall do all of the following:

(a) Identify the services to be provided.

(b) Stipulate that services may be provided only with the express authorization of the hospice care program.

(c) Describe the manner in which the contracted services are coordinated, supervised, and evaluated by the hospice care program.

(d) Delineate the role or roles of the hospice care program and the contractor in the admission process, patient and family assessment, and the interdisciplinary team reviews.

(e) Stipulate the requirements for documenting that services are furnished in accordance with the contract and the requirements of Section 22-21-20 of the revised Code and this Chapter.

(f) Set forth the qualifications of the personnel providing the services.

(g) Stipulate that the hospice care program shall provide hospice care orientation and training sufficient to provide competent care to the person who provides the care under the contract.

(2) When a provider of a hospice care program arranges for a hospital, a home providing nursing care, or home health agency to furnish a component or components of the hospice care program to its patient, the care shall be provided by a licensed, certified, or accredited hospital, inpatient hospice, home providing nursing care, or home health agency pursuant to a written contract under which:

(a) The provider of a hospice care program furnishes to the contractor a copy of the hospice patient's interdisciplinary plan of care which specifies the care that is to be furnished by the contractor.

(b) The regimen described in the established plan of care is continued while the hospice patient receives care from the contractor, subject to the patient's needs, and with approval of the coordinator of the interdisciplinary team.

(c) All care, treatment, and services furnished by the contractor are entered into the patient's medical record.

(d) The designated coordinator of the interdisciplinary team ensures conformance with the established plan of care.

(e) The contractor complies with the requirements of these rules.

(f) Those hospices not providing inpatient care shall encourage any hospital contracting for inpatient care to offer temporary limited privileges to the hospice patient's attending physician while the hospice patient is receiving inpatient care from the hospital.

(3) The hospice care program shall assure the continuity of patient and family care in the home, outpatient, and inpatient settings.

(4) The hospice care program shall retain professional management responsibility for contracted services, shall ensure that those services are furnished in a safe and effective manner by persons meeting the qualifications prescribed by this Chapter, and in accordance with the patient's plan of care and the other requirements of this Chapter.

(5) The hospice care program shall retain responsibility for payment for services provided by a contractor.

**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.
**History: New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000.

**420-5-17-.10 Volunteer Services.**

(1) Each hospice care program shall use trained volunteers to assist with the provision of administrative or direct patient care services and shall have trained volunteers available to hospice patients and hospice patients' families as needed. Volunteers shall provide services under the supervision of a designated, qualified, and experienced hospice staff member.

(2) Each hospice care program shall document active and ongoing efforts to recruit and retain volunteers.

**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.
**History: New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000.

**420-5-17-.11 Nursing Services.**

(1) Each hospice care program shall provide nursing care and services by or under the supervision of a registered nurse. The program shall direct and staff nursing services sufficient to meet the nursing needs of all of the hospice care program's patients. The program shall specify the patient care responsibilities of nursing personnel.

(2) Each inpatient hospice shall provide nursing services twenty-four hours a day. These services shall be sufficient to meet the total nursing needs of the hospice patients residing in the hospice. Each shift shall be staffed by a registered nurse who provides direct patient care and directs the care of LPNs and aides. This requirement does not apply to hospice patients who are admitted to a Medicare or Medicaid certified facility such as a skilled nursing facility for respite care only.

(3) Each hospice agency that provides respite care in a non-hospice inpatient facility shall have a written agreement with that facility to ensure that:

(a) Each patient receives all necessary care and services in accordance with the patient's individualized plan of care in a safe and effective manner by qualified personnel.

(b) The hospice agency retains administrative oversight for all staff qualifications, supervision and training in the hospice model for respite care

**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.
**History:** **New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000. **Amended:** Filed July 22, 2013; effective August 26, 2013.

**420-5-17-.12 Medical Social Services.**

(1) Each hospice care program shall provide medical social services to each patient and family as needed. A social worker shall provide these services under the direction of a physician.

(2) Each inpatient hospice facility shall provide medical social services sufficient to meet the social service needs of the hospice patients residing in the facility.

**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.
**History:** **New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000.

**420-5-17-.13 Personal Care Services.**

(1) Each hospice care program shall provide personal care services in the scope and frequency required to meet the needs of its patients and their families. Personal care services include assistance with activities of daily living, personal care, ambulation and exercise, household services essential to health care at home, assistance with self-administration of medications, and preparation of meals.

(2) Personal care services shall be provided by individuals who have been selected on the basis of such factors as a caring attitude toward patients and their families, ability to read, write, and carry out instructions, and maturity and ability to cope with the demands of the job.

(3) The hospice care program shall ensure that those individuals providing personal care services have been trained in methods of assisting patients to achieve maximum self-reliance, principles of nutrition and meal preparation, the aging process and emotional

problems of illness, procedures for maintaining a clean, healthful, and pleasant environment, changes in a patient's condition that should be reported, the philosophy of hospice care and of the hospice care program, ethics, confidentiality, and record keeping.

(4) A registered nurse shall prepare for each aide written instructions for patient care which are consistent with the interdisciplinary plan of care.

(5) A registered nurse shall make and document a supervisory visit to the patient's residence at least every two weeks to assess the performance of the aide services.
**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.
**History: New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000.

**420-5-17-.14 Physician Services.**

(1) Patients in need of health care which can be met by the hospice are admitted to the hospice only upon the recommendation of, and remain under the care of, a physician. Each patient or sponsor designates a physician.

(2) There is made available prior to or at the time of admission patient information which includes current medical findings, diagnoses, and orders from the physician for the immediate care of the patient. A summary of prior treatments are made available at the time of admission or within 48 hours thereafter. The following provisions are applicable:

(a) If orders are from a physician other than the attending physician, they shall be communicated to the attending physician and verification of such shall be entered into the medical record by the nurse who took the orders from the physician.

(b) Physician's verbal orders for drugs, treatments, diets, etc., (e.g., oral orders, telephone orders, recopied orders, standing orders) are reduced to writing on the physicians' order sheet by a licensed nurse, physician, or pharmacist. They are dated and signed by the person receiving or transcribing the order. Such orders are dated and signed by the attending physician at the time of the next visit, but in no case longer than 30 days after dating and recording the order.

**Dietary counseling** means education and interventions provided to the patient and family regarding appropriate nutritional

intake as the patient's condition progresses and is provided by qualified individuals, which may include a registered nurse, dietitian, or nutritionist, when identified in the patient's plan of care.

(c) The attending physician shall designate an alternate physician to attend the patient in his/her absence.

(d) The hospice has written procedures, available at the nurses' station, that provides for having a physician available to furnish necessary medical care in case of emergency.

(e) In each inpatient hospice the physician shall write/ dictate, date, and sign a progress note at the time of each patient's visit or within 7 days.

(f) In each inpatient hospice any changes in the interdisciplinary treatment team care plan shall be dated and signed by the physician at the time of each visit or within 7 days.

(g) The physician is responsible for the development of a discharge summary within 30 days after discharge or death.

(h) Each inpatient hospice must have a list of names and telephone numbers of physicians to be called in the event of an emergency.

(3) **Documentation of emergencies, accidents and injuries.** All the hospices shall have policies and procedures established relative to documentation of emergencies, accidents, and injuries to patients and staff.

(a) Sufficient information shall be documented in the medical record and/or on the accident and incident record to reflect facts about the incident, injuries, actions taken, and physician contacted. Dated and signed entries in the medical record and/or the incident and accident record shall be made by the physician and other appropriate hospice staff.

(b) The manager and appropriate staff shall be provided written reports of accidents and injuries.

(c) These reports shall serve the medical director and other appropriate staff as a basis for a written recommendation for corrective action.

**Author:** Jimmy D. Prince, Dana Billingsley
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.
**History: New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000. **Amended:** Published March 31, 2022; effective May 15, 2022.

**420-5-17-.15 Counseling And Bereavement Services.**

(1) Each hospice care program shall make available counseling services to the hospice patient and the patient's family. Counseling services shall include dietary, spiritual, and any other necessary counseling services while the patient is enrolled in the hospice care program. Counseling services shall be provided by a qualified interdisciplinary team member or one or more other qualified individuals, as determined by the hospice care program.

(2) The hospice care program shall make reasonable efforts to arrange for contacts by clergy, chaplain, and other members of religious organizations in the community to patients who request such services and shall apprise patients of this opportunity.

(3) Each hospice care program shall provide bereavement services, as needed, for hospice patients' families. These services shall be provided for at least one year after the patient's death unless discontinued by the family. Bereavement services shall be provided under the supervision of a designated qualified professional.
**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.
**History: New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000.

**420-5-17-.16 Admission Of Patients To The Hospice Care Program.**

(1) A hospice care program shall not admit any individual who does not meet the definition of a hospice patient.

(2) A hospice care program shall obtain informed consent from the patient. The program shall require that the patient, or the patient's authorized representative, sign an informed consent form.

(3) A hospice care program shall permit a hospice patient to withdraw consent for hospice care at any time.

(4) Prior to or within forty-eight hours after admission of each patient, a hospice care program shall obtain an oral statement from the patient's attending physician, if the patient has an attending physician, and the medical director of the hospice care program or the physician member of the interdisciplinary team, certifying that the patient is terminally ill. The program shall obtain written confirmation of the oral statement within thirty days after admission or prior to billing for any services,

whichever is earlier. The written certification statement shall be signed by the patient's attending physician and the medical director of the hospice care program or the physician member of the interdisciplinary team.
**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.
**History: New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000.

**420-5-17-.17 Quality Assurance.**

(1) Each hospice care program shall conduct an ongoing, comprehensive, integrated, self-assessment of the quality and appropriateness of care provided by the program including inpatient care, home care, and care provided under contracts with other persons or public agencies.

(2) The hospice care program shall designate an individual or individuals to be responsible for the quality assurance program. The designee or designees shall implement and report on activities and mechanisms for monitoring the quality of care, identify and resolve problems, and make suggestions for improving care. The designee or designees shall provide their reports to the governing body of the program.

(3) The hospice care program shall use the findings of the quality assurance program to correct identified problems and to revise hospice care program policies if necessary.

(4) Documentation of findings, recommendations, and corrections shall be maintained.
**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.
**History: New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000.

**420-5-17-.18 Medical Records.**

The hospice develops policies and procedures governing all aspects of the medical record.

(1) **Records Shall be Confidential.** When an individual enters a hospice program, records and information regarding him are confidential. Access to these records shall be limited to the patient, designated team members, physicians, others having professional responsibility, representatives of the State

Board of Health, and such other persons as the patient may delegate.

(2) Each hospice care program shall establish and maintain a central clinical record for each hospice patient receiving care and services from the program and his or her family. The record shall be established and maintained in accordance with accepted principles of practice.

(3) The clinical record shall be a comprehensive compilation of information that is documented promptly for all services provided. The record shall be organized systematically to facilitate retrieval of information. Entries to the clinical record shall be made and signed by the person providing the service. All services, whether furnished by employees, persons under contract, or volunteers, shall be documented in the clinical record.

(4) Each clinical record shall contain at least the following information:

(a) Identification data.

(b) Pertinent medical history.

(c) Consent and authorization forms.

(d) Initial and subsequent assessments.

(e) The interdisciplinary plan of care.

(f) Documentation of all services and events, such as evaluations, treatments, and progress notes.

(g) The hospice care program shall provide for storage of the central clinical records to protect them against loss, destruction, and unauthorized use.

(5) **Completion of Records and Centralization of Reports.** Medical records of discharged patients shall be completed within 60 days. All clinical information pertaining to patient’s stay is centralized in the patient’s medical record.

(6) **Retention and Preservation.** Medical records are retained for a period of time not less than five years from date of discharge or, in the case of a minor, three years after the patient becomes of age under state law.

(7) **Disposition of Medical Records.** When a Hospice ceases to operate either voluntarily or by revocation of its license, the governing body (licensee) at or prior to such action shall develop a proposed plan for the storage, access and disposition of its medical records. Such plan shall be

submitted in writing to the Alabama Department of Public Health for review and approval. The plan must contain provisions for proper storage, safeguarding and confidentiality, as well as access to, transfer or disposal of medical records.

**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.
**History:** **New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000.

**420-5-17-.19 Dietetic Services.**

Those facilities located within a hospital or nursing home shall meet the dietary licensure requirements of that facility. In the inpatient hospice classified as a health care-1imited care facility, the provision of dietary services shall comply with the following:

(1) **Staffing.** A consulting qualified dietitian is available to assist in nutritional assessment menu planning, inservicing staff and evaluating safe food production. This information shall be included in the quality assurance program. A facility which does not provide the services of a certified dietary manager must, as a minimum, train all employees through the county health departments' food managers training course or a comparable course.

(a) If consultant dietetic services are used, the consultant's visits are at appropriate times and of sufficient duration and frequency based upon the size and needs of the hospice to provide continuing liaison with medical and nursing staffs, advice to the manager, patient counseling, guidance to the supervisor and staff of dietetic service, approval of all menus, and participation in development or revision of dietetic policies and procedures and in planning and conducting inservice education programs.

(b) The hospice employees sufficient supportive dietetic personnel competent to provide a hygienic dietary service that meets the daily nutritional and special dietary needs of patients, and provides palatable and attractive meals.

(2) **Preparation and Service of Food.** Foods are prepared by methods that conserve nutritive value, flavor, and appearance and are attractively served. Prepared food is maintained on the serving line at 140 degree F. Cold food, particularly susceptible food such as milk, etc., shall be maintained at less than 45 degree F. at serving. If a patient refuses food

served, appropriate substitutes of similar nutritive value are offered during that meal.

(a) If patients require assistance in eating, food shall be maintained at 100 degree F. serving temperature until assistance is provided.

(b) Dietetic service personnel shall practice hygienic food handling techniques.

(c) Employees engaged in the handling, preparation, and serving of food shall:

1. Wear clean clothing at all times.

2. Shall have hair appropriately covered with hair nets or caps.

3. Wash their hands thoroughly before starting work each day, immediately after contact with any soiled matter, immediately after working with raw meats, and before returning to work after leaving the work area. Personnel with infections, or open cuts may not handle foods.

(d) Food service employees shall not be assigned duties outside the dietetic service that interfere with the sanitation, safety, or time required for dietetic work assignments.

(e) There shall be no use of tobacco products in the dietary department.

(f) The public, patients, and employees shall be allowed to eat or smoke only in designated areas.

(3) **Sanitary Conditions.** Food is procured from sources approved or considered satisfactory by state authorities and stored, prepared, distributed, and served under sanitary conditions. Waste is disposed of properly, i.e., kitchen garbage and trash shall be placed in containers with tight fitting lids and stored in a screened or refrigerated space pending removal. Kitchen garbage and trash shall not be allowed to accumulate in the kitchen and shall be removed from the premises at frequent intervals. After emptying, all soiled garbage and trash cans shall be washed thoroughly inside and out and dried before reuse.

(a) **Protection from contamination.** All foods and food ingredients shall be so packaged, stored, handled and served as to be protected from dust, flies, roaches, rats, unsanitary handling, droplet infection, overhead leakage, sewage backflow, and any other contamination.

Sugar, syrup and condiment receptacles shall be provided with tight fitting lids, and shall be kept covered when not in use. Refrigerated food shall be covered, labeled and dated. All foods removed from original container shall be properly protected and labeled.

(b) **Ice.** All ice used in the inpatient hospice shall be made of water obtained from a source approved by the State Board of Health. Ice shall be protected from splash, drip, and hand contamination during storage and service. All ice shall be free of visible trash and sediment. Ice scoops shall be stored in a manner so as to protect them from becoming soiled or contaminated between usage.

(c) Families are allowed to store home cooked food for their patient. This storage shall be readily available and meet the same standards as foods prepared by the hospice. Food brought from home will not be commingled with the food prepared for other patients.

(4) **Storage and Service of and Ice Cream.** All milk and fluid milk products shall be served only from the original containers in which they were received from the distributor provided, however, that this shall not apply to cream for coffee, cereals, and milk mixed drinks which may be dispensed from a readily cleanable container approved for such use.

(a) Milk and fluid milk products shall not be stored so that any bottle or container from which the milk or milk products is to be poured or consumed may become submerged in water, or so that their tops may become contaminated from drip or contact with foods, ice, etc.

(b) All purchased ice cream and other frozen desserts shall be from an approved source. No contaminating substance shall be stored with or over containers of ice cream. Ice cream dippers, spatulas, etc., shall be stored between uses in clean running water in a sanitary manner.

(c) Equipment used for dispensing or storage of ice cream or other frozen desserts shall be thoroughly cleaned following each use.

(d) Raw eggs shall not be served.

(e) Dry milk powder may be used in cooked products or special formulas. Milk made from dry milk powder shall not be served as a beverage.

(5) **Physical Facilities.** Location and space requirements. Food service facilities shall be located in a specifically

designated area and shall include the following rooms and/or spaces: kitchen, dishwashing, food storage and dining room.

(a) Kitchen.

1. Size and dimensions. The kitchen shall be of such size and dimensions as to:

(i) Permit orderly and sanitary handling and processing of food.

(ii) Avoid overcrowding and congestion of operations.

(iii) Provide at least 3 feet between working areas. Such space shall be wider than 3 feet if it is used as a passageway.

(iv) Provide a ceiling height of at least 8 feet.

2. Equipment. As a minimum, the kitchen shall have the following:

(i) Range. Facilities classified as large shall have a heavy duty, institutional type range.

(ii) Refrigeration. Facilities classified as large shall provide institutional or commercial type refrigeration. But in no case shall space be less than 2 cubic feet per bed for refrigerated space. Freezer space shall, as a minimum, be provided at a rate of 1 cubic foot per bed of frozen food storage. Each unit shall be supplied with a thermometer.

(iii) Stainless steel cooking and baking counter or table.

(iv) Commercial type dishwashing machine, with clean dish counter and soiled dish counter.

(v) Ice machine/maker.

(vi) Fire extinguisher, 10 lb. carbon dioxide or other type approved by local or state fire marshal.

(vii) Rack, pots and pans.

(viii) Three-compartment sink with rinsing compartments equipped to maintain supplied water at a minimum of 180 degree F.

(ix) Containers for flour, sugar, coffee, tea, etc.

(x) Garbage cans with tight-fitting covers.

(xi) Coffee maker.

(xii) Storage space for silverware and cutlery.

(xiii) Pots, pans, silverware, dishes, etc.

(xiv) Clock.

(xv) Separate sink for meat and vegetable preparation.

(xvi) Food mixers.

(xvii) Adequate storage space.

(xviii) Tray set up facilities, adequate to maintain food at proper temperatures (hot foods 140 degree F. or greater - cold foods 45 degree or below).

(xix) Storage for tray set up utensils (dishes, table flatware, trays, etc.).

(xx) Blender.

(b) Food storage. A well-ventilated, food storage room or pantry shall be provided. Adequate shelving, bins, suitable cans, and/or raised platforms shall be performed. Perishable food shall be stored at least 4 inches above the floor. The storage room shall be of such construction as to prevent the invasion of rodents and insects, the seepage of dust and water leakage, or any other source of contamination.

(c) Water heating equipment. Facilities for heating an ample supply of water, with adequate pressure, for all washing purposes shall be provided. Equipment shall be capable of heating water to a temperature of not less than 180 degree F.

(d) Floors. Floors in food service areas shall be of such construction as to be easily cleaned, sound, smooth, nonabsorbent, without cracks or crevices, and shall be kept in good repair. Painted concrete floors are not acceptable. Where wet cleaning methods are employed, the floors shall be provided with approved and conveniently located facilities for the disposal of floor wash water.

(e) Walls and ceilings. Walls and ceilings of food service area shall be of tight and substantial construction. The walls and ceilings shall be without horizontal ledges and shall be washable up to the highest level reached by splash and spray. Roofs and walls shall be maintained free of leaks. All openings to the exterior shall be provided with doors or windows which will prevent the entrance of rain or dust during inclement weather.

(f) Screens on outside openings. Openings to the outside shall be effectively screened or suitable provisions made equal to screening. Screen doors shall open outward and shall be equipped with self-closing devices.

(g) Lighting. The kitchen and dining room shall be provided with unobstructed natural light through windows equivalent to not less than 10 percent of the floor area. Artificial light properly distributed and of an intensity of not less than 50 foot candles shall be provided.

(h) Ventilation. The food service area shall be ventilated in a manner that will maintain comfortable working conditions, remove objectionable odors and fumes, and prevent excessive condensation.

(i) Employee toilet facilities. Toilet facilities shall be provided for employees. Toilet rooms shall not open directly into any room in which food is prepared, stored, displayed, or served, nor into any room in which utensils are washed or stored. Toilet rooms shall include a lavatory, soap dispenser, towel cabinets, hot and cold water, and covered receptacle and shall be well lighted and ventilated.

(j) 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 a supply of soap, disposable towels, covered receptacle, and hot and cold water through a mixing valve or combination faucet. The use of a common towel is prohibited. Hands shall not be washed in sinks where food is prepared.

(k) Refrigeration facilities. Where separate refrigeration can be provided, temperatures for storing perishable foods are: 32 degrees to 38 degrees F. for meats, 40 degrees F. for dairy products, 45 degrees to 50 degrees F. for fruits and vegetables. If it is impractical to provide separate refrigeration, the temperature shall be maintained at 38 degrees to 45 degrees F.

(l) Equipment and utensil construction. Equipment and utensils, except single service utensils, shall be so constructed as to be easily cleaned and shall be kept in good repair. No cadmium plated, lead, or readily corrodible utensils or equipment shall be used.

(m) Separation of kitchen from patient room and sleeping quarters. Any room used for sleeping quarters shall be separated from the food service area by a solid wall without communicating openings. Sleeping accommodations, such as a cot, bed, or couch, shall not be permitted within the food service area.

(6) **Food handling procedures.**

(a) Floors, walls, and ceilings of all rooms in the food service area shall be free of an accumulation of rubbish, dust, grease, dirt, insects, etc.

(b) All equipment within the food service area shall be clean and free from dust, grease, and dirt, etc.

(c) Tables and counters upon which food is served shall be kept clean. Tablecloths, if used, shall be clean. Cloth napkins shall be laundered after each use. Cloths used for wiping tables, counters, fountains, etc., shall be kept in a sanitizing solution between uses.

(d) All repeated service utensils shall be thoroughly cleaned after each use. Single service utensils shall be used only once. All multi-use utensils shall be thoroughly cleaned following each use or meal period. Multi-use utensils used for storage shall be thoroughly cleaned when emptied, or more often if necessary.

(e) Dishes and utensils washing, disinfection and storage.

1. Dishwashing water shall be changed with sufficient frequency to avoid contamination. Final rinse water of a minimum of 180 degree F. shall be kept clean and clear.

2. All repeated service and multi-service utensils and dishes, after washing and rinsing, shall be sanitized by:

(i) Immersion for at least one-half minute in clean, hot water at a temperature of at least 180 degree F.; or

(ii) Immersion for at least one minute in a clean solution at least 50 parts per million of

chlorine and at a temperature of at least 75 degree F.; or

(iii) Immersion for at least one minute in a clean solution containing at least 12.5 parts per million of available iodine, pH not higher than 5.0, and at a temperature of at least 75 degree F.; or

(iv) Other methods approved by the State Board of Health.

3. If properly maintained, 180 degree F. dishwashers may be used for the cleaning of multi-use utensils. Procedures that must be followed for acceptable results include:

(i) Adequate scraping of utensils.

(ii) Monitoring of predetermined temperature.

(iii) Maintaining clean equipment.

(iv) Residue-free solutions.

(v) Monitoring of cleaning and germicidal solutions in the low temperature process (the concentration of chemical in the rinse spray shall be maintained at least 50 ppm or as recommended by the manufacturer of the chemical).

(vi) Thoroughly air drying the cleaned utensils.

4. After washing, rinsing, disinfecting, and drying, all repeated service and multi-use utensils and dishes shall be stored in a clean place that is dry, protected from flies, roaches, dust, splash and other contamination from hands and clothing.

5. All unused single service utensils shall be stored in the same manner as repeated service utensils.

**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.
**History:** **New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000.

**420-5-17-.20 Medical Supplies, Pharmaceuticals And Biologicals.**

(1) Each hospice care program shall arrange for provision of medical supplies, appliances, drugs, and biologicals to patients as needed for the palliation and management of the patient's terminal illness and related conditions. The program shall ensure that drugs and biologicals can be obtained at all times.

(2) Each hospice care program shall ensure that instruction is provided to patient and/or family regarding proper administration of drugs and biologicals and their side effects with documentation in the patient's record.

(3) The inpatient hospice has written policies and procedures, developed with the advice of a pharmacist, which ensures that drugs and biologicals are obtained for patients on a timely basis, they are dispensed and administered according to all federal, state and local laws, and provide for appropriate handling and control of all drugs and biologicals. Whether drugs or biologicals are obtained from community or institutional pharmacies or stocked by the hospice, the hospice is responsible for ensuring the availability of such drugs or biologicals for its patients and that pharmaceutical services are provided in accordance with accepted professional principles and all appropriate federal, state and local laws.

(4) All policies and procedures shall be reviewed and updated at least annually by at least a pharmacist, the director of nursing services, the manager and one physician.

(5) Supervision of services in the inpatient hospice. Pharmaceutical services are under the general supervision of a qualified, registered pharmacist. The pharmacist may serve the inpatient hospice on a full-time, part-time, or consultant basis.

(a) If the pharmacist is not employed full-time, a sufficient number of hours are devoted on a regularly scheduled visit to carry out all responsibilities. The number of hours devoted are based on the size and needs of the hospice.

(b) The pharmacist reviews the drug regimen of each patient on admission, every 14 days and reports any irregularities to the individual who is authorized to make a change.

(c) The pharmacist submits a written report each month to the medical director, director of nurses, and the manager that defines his/her activities, drug regimen review result findings and recommendations. There shall be documented

evidence by the director of nurses and/or the manager as to corrective action taken.

(6) **Hospice Pharmacy.** If the hospice has a pharmacy, a licensed pharmacist is employed to administer the pharmacy.

(a) Facilities without a pharmacy must have provisions for promptly and conveniently obtaining prescribed drugs and biologicals from community or institutional pharmacies.

(b) In facilities without a pharmacy but maintaining a supply of drugs, the pharmacist is responsible for assuring the control of all drugs and the maintenance of readily reconcilable records of receipt and disposition.

(7) **Control and Accountability.** All hospices shall have written policies and procedures for the control and accountability of all drugs and biologicals throughout the hospice to prevent unauthorized use and/or distribution. Drugs and biologicals used in the hospice are obtained and dispensed and/or destroyed in compliance with federal and state laws.

(a) Hospices using experimental drugs or biologicals shall have written procedures governing their use which are in compliance with all laws relative to their use.

(b) The inpatient hospice shall have readily available records of receipt and disposition (for all controlled drugs) that provide sufficient detail to enable an accurate reconciliation.

(c) The inpatient hospice shall maintain readily traceable control records of schedule II and III drugs which lists on individual patient’s records each type and strength of drug used along with the following information: date, time administered, name of patient, dose, physician’s name, signature of person administering the dose and balance on hand.

(d) The individual medication record may serve as a record of receipt and disposition of controlled drugs listed in schedule IV and V and drugs not subject to frequent abuse as well as non-controlled drugs.

(8) **Destruction of Drugs.** Each hospice program develops written policies and procedures for the destruction of drugs and biologicals when those drugs are no longer needed by the patient. Controlled substances and legend drugs dispensed to patients, that are unused because the medication is discontinued, or because the patient 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.

(a) Discontinued medications and medications of discharged, deceased and transferred patients in the inpatient hospice shall be destroyed within a reasonable period of time not to exceed 30 days.

(b) Medications of patients transferred from a home care hospice to a hospital or inpatient hospice may be retained until the patient has returned. The physician's order will dictate whether or not the patient is to use the same drug regimen as previously ordered. Medications not ordered by the physician should be handled in accordance with the hospice policy regarding medication destruction.

(c) Destruction of outdated, unused or discontinued medications for patients, discharged patients, deceased patients, or patients transferred to another hospice shall be carried out on the premises of the inpatient hospice.

(d) Destruction records of controlled substances in the inpatient hospice must be completed to include:

1. Name and address of hospice.

2. Date of destruction.

3. Method used in destruction.

4. Prescription number, name of drugstore from which the medicine was dispensed, patient's name, name and strength of drug destroyed, amount destroyed and reason for destruction.

(e) The pharmacist will verify that the list of drugs to be destroyed is accurate and with the director of nurses or assistant director of nurses, will carry out destruction. Both shall sign the destruction form indicating amounts listed are correct and have been destroyed. There shall be a third witness who may be a law enforcement official, management or supervisory personnel, i.e., manager, LPN charge nurse, etc. Copies of destruction records will be maintained by the pharmacist and the hospice.

(f) When destruction of medications is conducted within the patient's home by the hospice nurse, this procedure shall be witnessed by one or more persons.

(g) When medications are destroyed, a destruction record shall be completed for each drug destroyed and placed in the patient's completed medical record.

(h) If a separate file of destruction records is to be maintained, they must be retained for a period of not less than two years.

(i) In an inpatient hospice legend drugs and over-the-counter drugs that are not controlled drugs may be destroyed in the same way as controlled drugs. The exception would be when the pharmacist and director of nurses or assistant director of nurses verify and destroy medications, a third person is not required. The records and filing shall be the same as for controlled drugs.

(9) **Labeling of Drugs and Biologicals.** All containers of medicines and drugs shall be properly and plainly labeled, including name and strength of drug, patient's name, ordering physician, date of filing, 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.

(a) Use of and labeling of generic drugs shall comply with State Board of Pharmacy requirements.

(b) When authorized substitution of a drug takes place, the medication administration record and the label of the medication must contain the name of the actual drug dispensed in accordance with state pharmacy law.

(c) When over-the-counter (non-prescription) medicines and drugs are maintained for inpatient hospice patients, each medication shall be plainly labeled with the patient's name, the name and strength of the drug, and the expiration date. Additional labeling information may be at the discretion of the hospice as related in its policies and procedures except that manufacturer's labeling information must be present in the absence of prescription labeling. Over-the-counter medications (non-prescription) to be maintained as stock by the inpatient hospice shall be labeled with the name and strength of the drug, lot and control number, and expiration date except in those cases where the manufacturer's label is present.

(d) In the inpatient hospice the contents of all individual prescriptions shall be kept in the original container bearing the original label.

(e) Procedures shall be developed to assure proper control and labeling for medications provided a patient upon leaving the inpatient hospice on a temporary absence.

(f) 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 management, nursing and pharmacy personnel and must comply with federal and state requirements.

(10) **Administration of Medicines and Drugs.**

(a) Drugs are administered only by licensed nursing personnel or following instruction, the patient and his family in accordance with all federal, state and local laws.

(b) Drugs and biologicals shall not be administered to patients unless ordered by a physician duly licensed to prescribe drugs. Such orders shall be in writing over the physician's signature. Medications, including over-the-counter (OTC) medications such as aspirin, bufferin, Tylenol, mild laxatives, gargles, ointments, etc., may be administered from a "standing physician's order" provided that they shall be reduced to writing on the physician's order sheet, signed by the individual transcribing the order, and signed and dated by the ordering physician.

(c) The method of medication administration for all inpatient hospices shall ensure:

1. Patients are accurately identified prior to administration of a drug.

2. Physicians' orders are checked at least daily to assure that changes are noted.

3. Drugs and biologicals are administered as soon as possible after doses are prepared not to exceed two (2) hours and they are administered by the same person who prepared the doses for administration, except when unit dose systems or similar systems are used where a licensed pharmacist has prepared the dose for administration.

4. Each patient has an individual medication administration record (MAR) on which the dose of each drug administered shall be properly recorded by the person administering the drug to include:

(i) Name, strength and dosage of the medication.

(ii) Method of administration to include site if applicable.

(iii) Times of administration.

(iv) The initials of persons administering the medication, except that the initials shall be identified on the MAR to identify the individual by name.

(v) Medications administered on a "PRN" or as needed basis shall be recorded in a manner as to explain the reason for administration and the results obtained.

The hospice shall have a procedure to define its methods of recording these medications.

(vi) Medications brought to the hospice by the patient or other individuals for use by that patient shall be positively identified as to name and strength, properly labeled, stored in accordance with facility policy and shall be administered to the patient only upon the written orders of the attending physician.

(vii) Medications shall not be retained at the patients' bedside nor shall self-administration be permitted except when ordered by the physician. These medications will be appropriately labeled and safety precautions taken to prevent unauthorized usage.

(viii) Medication errors and drug reactions are immediately reported to the director of nurses, pharmacist and physician and an entry made in the patients' medical record and/or an incident report. This procedure shall include recording and reporting to the physician the failure to administer a drug and/or the refusal of a patient to take a drug.

(d) The nurses' station or medicine room for all inpatient hospices shall have readily available items necessary for the proper administration and accounting of medications. Equipment would include items such as tablet counters, graduated measuring device, mortar and pestle (or other method to provide aseptic technique for the crushing of medications), medicine cups, drinking cups, sterile syringes and needles for injectables, etc.

(e) Each hospice shall have available current reference materials that provide information on the use of drugs, side effects and adverse reactions to drugs, and the interactions between drugs.

(11) **Conformance with Physicians' Drug Orders.** Each inpatient hospice shall have a procedure for at least quarterly monitoring of medication administration. This monitoring may be accomplished by a registered professional nurse or a pharmacist to assure accurate administration and recording of all medications.

(a) Each hospice shall establish procedures for release of medications upon discharge or transfer of the patient. Medications shall be released upon discharge or transfer only upon written authorization of the attending physician. An entry of such release shall be entered in the medical record to include drugs released, amounts, who received the drugs, and signature of the person carrying out the release.

(12) **Storage of Drugs and Biologicals.** Procedures for storing and disposing of drugs and biologicals shall be established and implemented by the inpatient hospice.

(a) There shall be a drug or medicine room/drug preparation area at each nurses' station of sufficient size for the orderly storage of drugs, both liquid and solid dosage forms, and for the preparation of medications for patient administration within the unit. In the event that a drug cart is used for storage and administration of drugs, the room shall be of sufficient size for storage of the cart without crowding.

1. Each drug preparation area 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. Where the hospice uses a drug cart for the storage, preparation, and administration of medications, there shall be a storage area of sufficient size to accommodate placement of the cart.

2. There shall be a separate area or cubicle for the storage of each patient's medications, except where a cart is used for the administration of drugs and biologicals.

3. There shall be an operable sink provided with hot and cold water within the medicine room or medication preparation area for washing hands or cleaning containers used in medicine preparation. Paper towels and soap dispenser shall be provided.

4. Sufficient artificial lighting shall be provided and the temperature of the medicine storage area shall not be lower than 48 degree F. or above 85 degree F. and the room must be provided with adequate ventilation.

5. Drugs and biologicals, including those requiring refrigeration, shall be stored within the medicine room or shall have separate locks if outside the medicine room. The refrigerator shall have a thermometer and be capable of maintaining drugs at the temperature recommended by the manufacturer of the drug.

6. No foods may be stored in the same storage area (i.e., cupboard, refrigerator, or drawer) with drugs and biologicals. The areas designated for drug and biological storage should be clearly marked.

7. Medication refrigerators shall not be used to store laboratory solutions or materials awaiting laboratory pickup.

8. Controlled substances listed in the Comprehensive Drug Abuse Prevention and Control Act of 1970 and its subsequent amendments, and other drugs subject to abuse, shall be stored in separately locked, permanently affixed compartments provided for that purpose, except under single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected and where drugs are stored on a drug cart.

9. The drug or medicine rooms shall be provided with safeguards to prevent entrance of unauthorized persons including locks on doors and bars on accessible windows.

10. Only authorized, designated personnel shall have access to the medicine storage area.

(b) Pharmacy. If a pharmacy is to be constructed within an inpatient hospice, plans shall be submitted to the Alabama Department of Public Health for approval.

1. The pharmacy shall comply with the rules and regulations of the Alabama State Board of Pharmacy governing physical and licensing requirements of a pharmacy.

(c) Poisonous substances and/or "external use only" drugs must be plainly labeled and stored separate from drugs and biologicals. No poisonous substance shall be kept in the following areas: kitchen and dining area or any public spaces or rooms. This section shall not prohibit storage within the drug or medicine room of approved poisonous substances intended for legitimate medicinal use, provided that such substances are properly labeled in accordance with applicable federal and state law.

(d) First aid supplies shall be kept in a place readily accessible to the person or persons providing care in the inpatient hospice.

(e) Emergency medication kits will be kept in accordance with Chapter 680-X-2 of the Alabama State Board of Pharmacy Rules and Regulations governing institutional pharmacies.

1. The contents of this kit will be determined by the medical staff and approved by the hospice. The kit shall be stocked only with drugs of an emergency nature and shall not be used as a routine source of supply for non-emergency medications.

2. There shall be a list of contents attached to or placed inside the emergency kit stating the name and strength of the drug and quantities/amounts available.

This list shall also contain supplies and/or equipment available in the kit.

3. There shall be written procedures for removal of drugs from the kit, records to be kept, method of charging for medications, and ready replacement of removed items.

4. The pharmacist shall inspect the emergency kit at least monthly and assure removal and replacement of any outdated medications.

5. Any discrepancies noted in the emergency kit shall be reported to the director of nurses and manager through the pharmacist's monthly report.

6. Procedures shall outline the method for obtaining emergency medications which are not stocked in the emergency kit.

7. Emergency medication kits may contain controlled substances utilizing the following conditions:

(i) The source from which a hospice may obtain controlled substances must be a DEA registered pharmacy or practitioner.

(ii) There shall be a maximum of three doses of any controlled substance stocked in the emergency kit.

(iii) The responsibility for proper control and accountability of the emergency medication kit shall rest with both the inpatient hospice and the DEA registrant providing the drug. The hospice 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.

(iv) Adequate security measures shall be provided for the emergency medication 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.

(v) 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 it has been given.

(vi) 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.

(f) Each hospice 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. The following rules apply to such a cabinet:

1. There shall be a minimum number of doses of any medication in the "STAT" cabinet based upon the established needs of the hospice.

2. There must be a list of contents, approved by the inpatient hospice, giving the name and strength of drug and the quantity of each.

3. There shall be records available to show amount received, name of patient and amount used, prescribing physician, time of administration, name of individual removing and using the medication, and the balance on hand.

4. There shall be written procedures for utilization of the "STAT" medicine cabinet with provisions for prompt replacement of used items.

5. 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.

**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.
**History:** **New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000. **Amended:** Filed June 23, 2004; effective July 28, 2004.

**420-5-17-.21 Laboratory And Radiological Services.**

(1) Policies and procedures list the source of laboratory and radiology services and defines whether these services are provided by the hospice or under arrangement with an outside source.

(2) A hospice which does not provide laboratory, radiology, or other diagnostic services, must make arrangements for obtaining these services.

(3) Services provided must meet all applicable federal, state and local laws.

(4) Laboratory services shall be obtained from a laboratory which is CLIA (1988) certified to provide these services. X-ray services may be provided by a portable X-ray supplier, a facility licensed by the state to provide X-ray services, or a radiologist's office.
**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.
**History: New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000.

**420-5-17-.22 Transfer Agreement.**

(1) The home care hospice has a written transfer agreement with one or more hospitals sufficiently close to the hospice's service area to make feasible the transfer of the patient and their records. This agreement provides the basis for effective working arrangements under which inpatient hospital care or other hospital services are available promptly to the facility's patients when needed. The agreement delineates the responsibilities assumed by both the hospital and the hospice.

(2) A hospital and a hospice shall be considered to have a transfer agreement in effect if, by reason of a written agreement between them or (in case the two institutions are under common control) by reason of a written understanding by the person or body which controls them, there is reasonable assurance that:

(a) Timely transfer and admission of patients will be effected whenever such transfer is medically appropriate as determined by the attending physician.

(b) There will be interchange of pertinent medical and other information necessary to determine appropriateness and/or degree of care required.

(c) Security and accountability for patients' personal effects are provided on transfer by the inpatient hospice.

**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.
**History: New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000.

**420-5-17-.23 Infection Control.**

All hospices shall establish an infection control policy. The inpatient hospice shall also comply with the following:

(1) **Reasonable Accommodations.** Reasonable accommodations shall be made for all patients with contagious disease. The nature and extent of said accommodations shall be determined by the interdisciplinary team.

(2) **Housekeeping.** The hospice employs sufficient housekeeping personnel and provides all necessary equipment to maintain a safe, clean, and orderly interior. An employee is designated as responsible for the services and for supervision and training of personnel. Nursing personnel are not assigned housekeeping duties. A hospice contracting with an outside source for housekeeping may be found to be in compliance with this section provided the hospice and/or outside resources meet the requirements of this section. Cleaning carts shall not be carried into patient rooms.

(3) **Linen.** The inpatient hospice has available at all times a quantity of linen essential for proper care and comfort of patients.

(a) Linens are handled, stored, processed, and transported in such a manner as to prevent the spread of infection.

(b) Linens on patients beds shall be free of tears and stains and shall be removed from linen storage when it is no longer suitable for patient use.

(c) Linens shall be washed in a final wash cycle of 160 degree F. unless chemicals are used.

(4) **Pest Control.** The hospice is maintained essentially free from insects and rodents through operation of a pest control program.

(5) **Premises.** The premises shall be kept neat and clean, and free from accumulated rubbish, weeds, ponded water or other conditions of a similar nature which would have a tendency to create a health hazard.

(6) **Infectious Waste.** Each hospice shall develop, maintain and implement written policies and procedures for the definition and handling of its infectious wastes. For the purposes of this rule, the following wastes shall be considered to be infectious wastes:

(a) Wastes contaminated by patients who may be infected with communicable diseases.

(b) Any cultures or stocks or microorganisms.

(c) Waste human blood and blood products such as serum, plasma, and other blood components.

(d) All discarded sharps (e.g., hypodermic needles, syringes, broken glass, scalpel blades, etc.).

(e) Other wastes determined to be infectious by the hospice, which should be set forth in a written policy.

(7) **Standards for Handling Infectious Waste Within a Hospice.**

(a) Segregation. Infectious wastes should be isolated from other waste at the point of generation within the hospice.

(b) Packaging infectious waste must be packaged in a manner that will protect waste handlers and the public from possible injury and disease that may result from exposure to the waste. Such packaging should provide for containment of the infectious waste from the point of generation up to the point of proper treatment or disposal. Packaging must be selected and utilized for the type of infectious waste the package will contain, how the waste will be treated and disposed, and how it will be handled and transported prior to treatment and disposal.

1. Contaminated sharps should be directly placed in leakproof, rigid, and puncture-resistant containers which must then be tightly sealed (e.g., taped closed or tightly lidded).

2. All containers, bags, and boxes used for containment and disposal of infectious wastes must be conspicuously identified.

3. Reusable containers for infectious wastes must be thoroughly sanitized each time they are emptied, unless the surfaces of the containers have been completely protected from contamination by disposable liners or other devices removed with the waste.

(c) Handling and transporting. After packaging, infectious wastes must be handled and transported to ensure and preserve by appropriate methods the integrity of the packaging, including the use of secondary containment where necessary.

1. Infectious wastes must not be compacted or ground (i.e., in a mechanical grinder) prior to treatment, except that pathological wastes may be ground to disposal.

2. Plastic bags of infectious wastes must not be transported by chute, dumbwaiter, conveyor belt, or similar device.

(d) Storage. Infectious waste must be stored in a manner which preserves the integrity of the packaging, inhibits rapid microbial growth and putrefaction, and minimizes the potential of exposure or access by unknowing persons.

1. Infectious waste must be stored in a manner and location which affords protection from animals, precipitation, and wind. It must be stored in a manner which does not provide a breeding place or food source for insects or rodents and does not create a nuisance.

(e) Managing incidents of noncontainment. In the event of spills, ruptured packaging, or other incidents where there is a loss of containment of infectious wastes, the hospice must ensure that proper actions are immediately taken to:

1. Isolate the area from the public and all non-essential personnel.

2. Repackage all spilled waste and containment debris to the extent practicable in accordance with the recommendations of sub paragraph (b) of this paragraph.

3. Sanitize all containment equipment and surfaces appropriately.

4. Complete incident report.

5. Written policies and procedures must specify how this will be done.

(f) Disposing of infectious wastes. Infectious wastes are disposed of in accordance with acceptable state regulations.

(8) **Standards for Handling of Non-infectious Wastes**. All garbage, trash, and other non-infectious wastes shall be stored and disposed of in a manner that must not permit the transmission of disease, create a nuisance, provide a breeding place for insects and rodents, or constitute a safety hazard. All containers for waste shall be water tight with tight fitting covers and shall be kept on elevated platforms constructed of easily-cleanable material. A hospice may incinerate non-infectious wastes in an on-site incinerator which is authorized to incinerate infectious/non-infectious waste in accordance with state regulations.

**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.

**History: New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000.

**420-5-17-.24 Disaster Preparedness.**

(1) The inpatient hospice has a written plan with procedures to be followed in the event of an internal or external disaster and for the care of casualties (patients and personnel) arising from such disasters.

(2) The hospice has an acceptable disaster plan with procedures to be followed in the event of fire, explosion, or other disaster. The plan is developed and maintained with the assistance of qualified fire, safety, and other appropriate experts, and includes procedures for prompt transfer/transport of casualties and records, instructions regarding the location and use of alarm systems, signals, and fire fighting equipment, information regarding methods of containing fire, procedures for notification of appropriate persons, specifications of evacuation routes and procedures, procurement of food, water, medical supplies, and other materials, detail personnel responsibilities relative to patient movement in and outside of the hospice for various situations such as tornadoes, fires, and other disasters. The plan shall be located in each department in a conspicuous place and kept current.

(3) The disaster program includes orientation and on-going training and drills for all personnel in all procedures so that each employee promptly and correctly carries out his specific role in case of a disaster.

(a) All employees are trained, as part of their employment orientation, in all aspects of preparedness for any disaster, and a record of this training is maintained in the employee's personnel record.

(b) Fire drills shall be conducted at least quarterly for each shift.

(c) Disaster drills shall be conducted at least semi-annually and all hospice personnel shall participate in at least one drill annually.

(d) Written observations of the effectiveness of the plan shall be filed and kept for at least three years for each fire drill and disaster drill. These observations shall include a list of all attendees.

**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.

**History: New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000.

**420-5-17-.25 Physical Plant Inpatient Hospices.**

The provisions of this section shall apply to all inpatient hospices licensed by the State Board of Health.

(1) **General Requirements.** The hospice shall have physical space for private patient and family visiting.

(a) The hospice shall provide accommodations for family members to remain with the patient throughout the night.

(b) The hospice shall provide accommodations for family privacy after a patient's death.

(c) The patient areas in the hospice shall have decor which is homelike in design and function.

(d) Patients shall be permitted to receive visitors, including small children, at any hour.

(2) **Location.**

(a) Each hospice shall be located so that they are free from undue noises, smoke, dust, or foul odors and shall not be located adjacent to railroads, freight yards, airports, industrial plants, disposal plants, cemeteries, funeral homes, or any other similar facility or activity. This rule shall not prevent additions to existing facilities.

(b) The location and construction of all 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 State Board of Health.

(c) 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.

(3) **Submission of Plans and Specifications.** When construction is contemplated, either for new buildings, conversions, additions, or major 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 Health Care Facilities."

(a) Minor alterations and remodeling which do not affect the structural integrity of the building, do not change functional operation, do not affect fire safety, and do not add beds over those for which the facility is licensed, need not be submitted for approval.

(4) **Inspections.** The State Board of Health and its authorized representative shall have access to the site for inspection.

(5) **Remolding and Alterations.** The remodeled area of existing facilities shall be upgraded to comply with the current requirements for new construction.

(a) Any remodeling to existing facilities shall not diminish the level of safety which existed prior to the start of the work.

(6) **General Requirements - Inpatient Hospices.** The provisions of this section shall apply to all inpatient hospices licensed by the State Board of Health on the effective date of these regulations.

(a) All hospices shall comply with the applicable regulations of the State Board of Health and the codes and standards as adopted by the State Board of Health, see Alabama Administrative Code, Rule 420-5-22, "Submission of Plans and Specifications for Health Care Facilities."

(b) The occupancy classification for all hospice facilities shall be "health care - limited care facility" as defined in the NFPA 101 Life Safety Code.

1. Exception 1 - a hospice located within a hospital shall meet the NFPA 101 Life Safety Code requirement for "health care - hospital" and all requirements for hospitals by the Department of Public Health in addition to those requirements contained within these regulations.

2. Exception 2 - a hospice located within a nursing home shall meet the NFPA 101 Life Safety Code requirement for "healthcare - nursing home" and all requirements for nursing homes by the Department of Public Health in addition to those requirements contained within these regulations.

(c) Water supply.

1. If at all possible, all water shall be obtained from a public water supply. If it is impossible to connect to a public water system, the private water supply shall be approved by the State Board of Health.

2. Water under pressure of not less than 15 lbs. per square inch shall be piped within the building to all sinks, toilets, lavatories, tubs, showers, and other fixtures requiring water.

3. An adequate supply of hot water shall be provided at all times throughout the facility. Temperature of hot water at plumbing fixtures used by patients shall be automatically regulated thermostatically by control valves and will not exceed 120 degree F.

4. In the laundry, provision shall be made to increase the water temperature to 160 degree F.

5. 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.

(d) Disposal of liquid and human wastes.

1. There shall be installed within the building a properly designed waste disposal system connecting to all fixtures to which water under pressure is piped.

2. All liquid and human waste, including floor wash water and liquid waste from refrigerators, shall be disposed of through trapped drains into a public sanitary sewer system in localities where such system is available.

3. In localities where a public sanitary sewer is not available, liquid and human waste shall be disposed through trapped drains into a sewage disposal system approved by the county health department and/or the State Board of Health.

4. The sewage disposal system shall be of a size and capacity based on the number of patients and personnel housed and employed in the institution. Where the sewage disposal system is installed prior to the opening of the institution, it shall be assumed, unless otherwise proven, that the system was designed for 10 or fewer persons.

5. Plumbing shall be 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 a manner not to constitute a source of contamination or create an unsanitary condition or nuisance.

(e) Solid waste.

1. Solid, non-infectious wastes shall be kept in leakproof, non-absorbent containers which shall be kept covered with tight-fitting lids, and shall be disposed of with sufficient frequency and in a manner to prevent a nuisance.

2. Solid wastes which are potentially infectious shall be burned on the premises in an incinerator approved by the State Board of Health or disposed of in a manner approved by the State Board of Health or its appropriate designated agency.

3. Trash chutes are prohibited.

(f) No part of a hospice may be rented, leased, or used for any purpose that is disruptive to the operation of the facility. Building uses not necessary to the facility operation shall be distinctly separated from the licensed facility operation. The State Board of Health shall approve all plans for functions not necessary to the operation of the facility. These areas shall be separated from the licensed facility by a two-hour fire separation.

(g) Construction type. The construction type of all buildings shall be classified according to National Fire Protection Association 220. All buildings shall meet the minimum construction requirements called for in the applicable occupancy sections of National Fire Protection Association 101 including automatic sprinkler system, if required.

(h) The building shall be structurally sound from leaks and excessive moisture, in good repair, and painted at sufficient intervals to be reasonably attractive inside and out.

(i) Distance to property line or adjacent structures.

1. There shall be a minimum of 30 feet of clear space measured perpendicular between a patient bedroom window and any building or the property line.

2. There shall be, as a minimum, 30 feet between any part of the building and any adjacent building(s) not conforming to the requirements of these regulations.

(j) The building area shall not occupy more than 40 percent of the site.

(k) There shall be telephones, as necessary, to summon help in case of fire or other emergency.

(l) Lighting.

1. All lighting shall be electric.

2. Each patient's room and bathroom shall have artificial light adequate for eating and other uses as needed. All entrances, hallways, stairways, ramps, cellars, rooms, storerooms, kitchens, laundries, and service units shall have sufficient artificial lighting to prevent accidents and promote efficiency of service.

3. Night lights shall be provided in bedrooms, hallways, and toilets and/or bathrooms that open into patient rooms. Glowing toggle switches are acceptable in toilets and/or bathrooms.

(m) Floors.

1. All floors are smooth and free from cracks and finished so that they can be easily cleaned. All floors in the facility except mechanical rooms shall be covered wall-to-wall with inlaid linoleums, resilient tile, hard tile, carpet, or the equivalent. A painted floor finish is not acceptable except in mechanical rooms and electrical rooms. Carpet is not acceptable in kitchens, utility rooms, toilets, baths, and janitor's closets.

2. All carpet must meet NFPA 101 requirements for "Class I" interior floor finishes.

(n) Patient bedrooms shall have an outside window, installed so that it can be opened from the inside without the use of tools or keys. Screens shall be provided on all operable windows.

(o) Walls and ceilings shall be of sound construction with an acceptable surface and maintained in good repair.

(p) A ceiling height of 8 feet or more (does not include furred area) shall be provided throughout the facility.

After the effective date of these regulations, a ceiling height of 7 feet 6 inches is allowed in corridors.

(q) Doors. To avoid the danger of a patient falling and blocking the swing of a door, all doors to patients' baths and toilets shall swing out or be double-acting and equipped with an emergency stop release.

(r) Fire hydrants. All facilities shall have access to public fire hydrant protection, or the equivalent approved by the local fire department or state fire marshal. Access to fire hydrants shall be within 500 feet.

(s) Handrails shall be installed on both sides of all corridors and shall be maintained in safe repair. Handrails shall return to the wall at the end of each handrail section.

(t) Nurse call system.

1. The facility shall have an electrical nurse call system at the side of each bed which will provide an audible and visual signal on an annunciator panel at the nurses' station.

2. Each facility shall have a light over the door to the bedroom in the corridor.

3. Nurse call system shall be provided in each patient toilet and bath.

(u) Elevators.

1. Facilities with patients 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 patient on a stretcher.

2. Routine inspections shall be made of elevators in accordance with codes and city ordinances.

(v) Exit signs. Exit signs shall be provided at all required exits. Additional exit signs shall be provided in corridors to indicate two directions of exit travel from any point. Additional exit signs for suites and places of assembly shall be installed as required.

(w) General storage. A general storage room shall be provided for the central storage of equipment, supplies, etc., at the rate of 8 square feet per bed and concentrated in one area. The storage room shall be designed to provide adequate and orderly storage so as to

prevent the use of corridors and non-storage areas for storage purposes. When any part of the facility is remodeled or renovated, general storage shall be provided at the rate of 8 square feet per bed. The general storage room shall be adequately ventilated. Space under stairs shall not be used for storage purposes.

(x) Facilities for physically handicapped. Necessary physical accommodations shall be made to meet the needs of persons with physical disabilities, sight and hearing disabilities, disabilities of coordination, as well as other disabilities in accordance with the standards adopted by the State Board of Health.

(y) Heating ventilation and air conditioning. The building shall be well ventilated at all times. Patients bedrooms shall be ventilated in such a manner as to supply fresh air and to prevent accumulation of objectionable odors. Kitchens, laundries, service rooms, toilets, bathrooms, and all inside rooms shall be vented to prevent offensive odors from entering other parts of the building.

1. Ventilating fans and blowers. Ventilating fans and blowers, if installed, shall not be so located that they will obstruct any required exit, stairway, or corridor and shall not create a draft from one floor to another.

2. Temperature to be maintained. The heating and cooling system must be capable of maintaining a temperature of 70 degree F. throughout the patient/ resident section of the building. The heating of all facilities shall be restricted to steam, hot water, or warm air systems employing central heating plants, or UL listed electric heating. The use of portable heaters of any kind is prohibited.

3. A laboratory, if provided, shall be ventilated and temperature controlled for proper equipment operation and/or test results.

(z) Ramps and inclines. Exterior and interior ramps and inclines, shall not be steeper than 1 footing rise in 12 feet of run, shall be finished with a non-slip surface and shall be provided with handrails on both sides.

(aa) Basements.

1. The basement shall be considered as a story if one-half or more of its perimeter is level with or above grade.

2. No patient/resident shall be housed in any room that is more than 50 percent below ground level.

(bb) Emergency power. An emergency generator shall be provided to supply power to the following:

1. Emergency corridor illumination.

2. Exit signs.

3. An exterior light at each exit.

4. Fire alarm system.

5. Smoke detection system.

6. Sprinkler system.

7. Life support systems by providing wall receptacles in the corridor at least every 50 feet and in at least two bedrooms in each nursing unit.

8. Telephone system.

9. Public address system.

10. Nurses' call system.

11. Medicine preparation area.

12. Sprinkler riser room.

13. Main electrical panel room.

14. Emergency generator location.

(cc) Existing mechanical and electrical systems. Mechanical and electrical systems installed prior to the effective date of these rules shall be inspected by local building, electrical, plumbing officials, or the state fire marshal or such other persons as the State Board of Health may request, and the recommendations regarding adequacy and safety shall be presented to the board.

(dd) Smoke dampers.

1. Smoke dampers shall be located in all ducts passing through smoke partitions. They shall be arranged to close upon activation of the fire alarm system by an initiating device.

2. Dampers shall remain closed while the fire alarm system is in the silence mode and shall remain closed until the fire alarm system is reset to normal.

(ee) Fire alarm.

1. A manual fire alarm system shall be provided to generate an audible and visual alarm throughout the facility.

2. Manual pull stations shall be installed at each exit.

3. The visual signal shall continue to flash while the alarm system is in the silence mode.

4. The fire alarm system shall sound upon activation of the automatic detection system, extinguishing system, and manual system.

5. In all buildings and additions connected by a common wall and corridor, the fire alarm system shall operate in all parts of the facility as one system.

(ff) Sprinkler. Building protection shall be provided throughout by an approved supervised automatic sprinkler system installed in accordance with NFPA 13 "standard for the installation of sprinkler systems."

(gg) Dead-end corridor shall not exceed 20 feet in length.

(hh) Rooms, spaces and equipment.

1. Each nursing unit shall have:

(i) Nurses' station.

(ii) Clean utility room.

(iii) Soiled utility room.

(iv) Medicine preparation area.

(v) Clean linen storage area. Cabinets on the corridor are not allowable.

(vi) Wheelchair and stretcher storage areas.

(vii) Janitor's closet.

(viii) On a nursing unit, no patient bedroom door shall be more than 120 feet from the nurses' station.

2. Bedrooms.

(i) Patients' bedrooms shall be located so as to minimize the entrance of odors, noise and other nuisances.

(ii) Patients' bedrooms shall be directly accessible from the main corridor of the nursing unit. In no case shall a patient's bedroom be used for access to another patient's room.

(iii) The bed capacity of any room shall not exceed four.

(iv) The minimum floor area of bedrooms (exclusive of toilets, closets, wardrobes, alcoves or vestibules) shall be as follows:

| | |
|---|---|
| Private bedroom | 120 square feet per bed |
| Multi-patient bedroom | 80 square feet per bed |

(v) 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 2 feet from the wall at the side of the bed and 3 feet from the wall at the foot of the bed.

(vi) Private bedrooms shall be provided at the ratio of 1 per 15 beds, or a major fraction thereof, which may include the special care or isolation room(s).

(vii) Each multi-patient room shall have permanently installed cubicle curtains and tracks to permit enclosing each bed with curtains to allow for the privacy of each patient without obstructing the passage of other patients to the corridor, closet, and toilet/lavatory.

(viii) Cubicle curtains installed in sprinklered building shall have ½ inch mesh openings extending 18 inches below the sprinkler deflector.

3. Accommodations for patients. The minimum accommodations for patient shall include the following:

(i) Bed patients shall be provided with an adjustable hospital bed with proper fitting mattress and personal care items.

(ii) Ambulatory patients shall be provided with a standard or adjustable hospital bed.

(iii) Pillows and necessary coverings.

(iv) Chair and bedside table.

(v) Chest for storage of clothing, toilet articles, and personal belongings.

(vi) Bedside electrical call system for summoning aid.

(vii) Waste paper receptacle.

(viii) Closet or wardrobe unit for each bed.

(ix) All facilities shall have a bed light mounted on the wall at the head of the bed, (operable by patient).

(x) All facilities shall provide a hand washing lavatory in each room. They may be omitted from a single-bed or a two-bed room when a lavatory is provided in an adjoining toilet or bathroom.

4. Isolation rooms shall be provided at the rate of not less than 1 private bedroom per 50 beds or major fraction thereof for the isolation of patients suffering from infectious diseases. The bedroom shall meet all of the requirements for bedrooms in these rules. Isolation bedrooms may be used to provide for the special care of patients with special needs. Isolation rooms shall have a private toilet.

5. The nurses' station for each nursing unit shall include as a minimum the following:

(i) Annunciator board for receiving patients' calls.

(ii) Cabinet space.

(iii) Storage space for current patients' charts.

(iv) Working space and accommodations for recording and charting purposes by facility staff.

(v) Medicine preparation room/area. (See storage of drugs and biologicals for specific requirements.)

6. All facilities shall provide a separate clean and soiled utility room for each nursing unit.

(i) The clean utility room shall contain as a minimum:

(I) Wall and base cabinets.

(II) Counter space.

(III) Single-compartment counter sink.

(IV) Paper towel cabinet.

(V) Soap dispenser.

(ii) The soiled utility room shall contain as a minimum:

(I) Paper towel and soap dispensers.

(II) Shelves.

(III) Cabinets for storage of poisonous substances; i.e., cleaning supplies, urine test products, etc.

(IV) Table or counter.

(V) Service sink for chemical sterilization of bed pans, urinals and commode pails, and/or pressure sterilizer.

(VI) Lavatory.

(VII) Soiled linen hamper.

7. Toilet and bathing facilities.

(i) For all patients bedrooms which do not have adjoining toilet and bath facilities, plumbing fixtures shall be provided within the nursing unit according to the following ratio:

| | |
|---|---|
| bathtubs or showers | 1 per 12 beds |
| lavatories | 1 per 6 beds |
| toilets (water closets) | 1 per 6 beds |

(ii) 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.

(iii) Grab bars shall be provided at each water closet.

(iv) Only one tub or shower shall be installed in a bath or shower room. The room may also contain a lavatory and a water closet.

8. Nourishment units.

(i) All facilities shall have a nourishment station containing the following:

(I) Work counter.

(II) Refrigerator.

(III) Hot plate or microwave.

(IV) Storage cabinet.

(V) Sink in the counter.

(VI) Ice machine.

(VII) Storage space for trays and dishes.

(VIII) Hand washing lavatory.

(ii) A clean utility room, separate from a soiled utility room, may be used as a nourishment station when the above requirements are met.

9. Patient dining and recreation areas shall be provided in accordance with the following:

(i) The total area set aside for these purposes shall be at least 20 square feet per bed.

(ii) The area shall contain at least one sitting area and a dining area.

(iii) Each nursing unit shall contain at least one sitting area.

(iv) The dining room shall be of such size and dimensions as to permit placing of dining tables and chairs to seat not less than 50 percent of the patients in the facility at one seating. The

dining room may also be used for recreational purposes. The kitchen shall not be used as a dining room for patients or personnel. Facilities shall provide a minimum of 12 square feet per person in the dining room.

(v) Dietary manager's office shall be located within the department and shall be equipped with necessary equipment.

10. Physical therapy areas, if provided, shall be in a specifically designated area and shall include equipment and areas as needed to meet specific patient requirements and shall also include storage space for linens, supplies, and equipment, a lavatory and a sink.

11. The Administrative Department and services shall be located in a specifically designated area and shall include the following:

(i) Administration.

(ii) Business Office/Accounting Services.

(iii) Lobby or waiting area.

12. All facilities shall provide maintenance services.

13. Employee toilets. Employee toilets shall be provided and shall include the following:

(i) Water closet.

(ii) Lavatory.

(iii) Soap dispenser.

(iv) Disposable towel dispenser.

(v) Covered waste receptacle.

**Author:** Jimmy D. Prince
**Statutory Authority:** Code of Ala. 1975, §§22-21-20, et seq.
**History: New Rule:** Filed August 20, 1993; effective September 23, 1993. **Repealed and New Rule:** Filed June 14, 2000; effective July 19, 2000. **Amended:** Filed June 18, 2002; effective July 23, 2002. ADDENDUM National Fire Protection Association 1 Battery March Park P.O. Box 9101 Quincy, MA 02269-9904 1-800-344-3555 Life Safety Code, NFPA-101 National Electrical Code, NFPA-70 Installation of Sprinkler Systems, NFPA-13 Air Conditioning and Ventilation Systems, NFPA-90a & 90b Standard Building and Plumbing Codes Standard Plumbing Gas & Mechanical Southern Building Code

Congress International 900 Montclair Road Birmingham, AL 35213 1-205-591-1853 National Plumbing Code American Society of Heating, Refrigeration and Air Conditioning Engineers (ASHREA) Publication Sales 1791 Tullie Circle, NE Atlanta, GA 30329-2305 American Society of Mechanical Engineers United Engineering Center 345 East 47th Street, NE New York, NY 10017 American Gas Association 1515 Wilson Boulevard Arlington, VA 22209

**420-5-17-A1 Addendum.**

National Fire Protection Association
1 Battery March Park
P.O. Box 9101
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1-800-344-3555

Life Safety Code, NFPA-101
National Electrical Code, NFPA-70
Installation of Sprinkler Systems, NFPA-13
Air Conditioning and Ventilation Systems, NFPA-90a & 90b

Standard Building and Plumbing Codes
Standard Plumbing Gas & Mechanical
Southern Building Code Congress International
900 Montclair Road
Birmingham, AL 35213
1-205-591-1853

National Plumbing Code

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1791 Tullie Circle, NE
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American Society of Mechanical Engineers
United Engineering Center
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New York, NY 10017

American Gas Association
1515 Wilson Boulevard
Arlington, VA 22209

**Author:**
**Statutory Authority:**
**History:**

**420-5-17-A2 Appendix.**

**§22-21-20. Definitions.** For the purpose of this article, the following terms shall have the meanings respectively ascribed to them by this section:

(1) HOSPITALS. General and specialized hospitals, including ancillary services; independent clinical laboratories; rehabilitation centers; ambulatory surgical treatment facilities for patients not requiring hospitalization; end stage renal disease treatment and transplant centers, including free-standing hemodialysis units; abortion or reproductive health centers; hospices; health maintenance organizations; and other related health care institutions when such institution is primarily engaged in offering to the public generally, facilities and services for the diagnosis and/or treatment of injury, deformity, disease, surgical or obstetrical care. Also included within the term are long term care facilities such as, but not limited to, skilled nursing facilities, intermediate care facilities, homes for the aged, domiciliary care facilities and related health care institutions when such institution is primarily engaged in offering room, board, laundry and personal assistance with activities of daily living and incidentals thereto. The term "hospitals" relates to health care institutions and shall not include the private offices of physicians or dentists, whether in individual, group, professional corporation or professional association practice. This section shall not apply to county or district health departments.

(2) PERSON. Such term includes individuals, partnerships, corporations and associations. (Acts 1975, 3rd Ex. Sess., No. 140, p. 382, §1; Acts 1979, No. 79-798, p. 1461; Acts 1991, No. 91-548, p. 1010, §1; Act 1997, No. 97-632, §1.)

**§22-21-21. Purpose of article.** The purpose of this article is to promote the public health, safety and welfare by providing for the development, establishment and enforcement of standards for the treatment and care of individuals in institutions within the purview of this article and the establishment, construction, maintenance and operation of such institutions which will promote safe and adequate treatment and care of individuals in such institutions. (Acts 1949, No. 530, p. 835, §1; Acts 1962, Ex. Sess., No. 122, p. 157, §1.)

**§22-21-22. License -- Required; exceptions.** No person shall establish, conduct or maintain any hospital as defined in Section 22-21-20 without first obtaining the license provided in this article. Hospitals operated by the federal government and mental hospitals under the supervision of the board of trustees of the Alabama State Hospitals shall be exempt from the provisions of this article. (Acts 1949, No. 530, p. 835, §2; Acts 1962, Ex. Sess., No. 122, p. 157, §2.)

**§22-21-23. License -- Application.** Any person desiring licensing under this article shall apply to the State Board of Health therefor. The applicant shall state the name of the applicant and whether an individual, partnership, corporation or other entity, the type of institution for which a license is desired, the location thereof and the name of the person in direct supervision and charge thereof. The person in charge of such hospital must be at least 19 years of age, of reputable and responsible character and in sound physical and mental health. Like evidence of fitness shall be submitted when required, except for age, as to those individuals employed at, or in, such hospital in a supervisory capacity. The applicant shall likewise submit evidence of ability to comply with the minimum standards provided in this article or by regulations issued under its authority. (Acts 1949, No. 530, p. 835, §4.)

**§22-21-24. License -- Fees; term; form; nontransferable; posting; renewal; hospital licensable when accredited by joint commission.** The application for a license to operate a hospital shall be accompanied by a standard fee of $200.00, plus a fee of $5.00 per bed for each bed over 10 beds to be licensed in accordance with regulations promulgated under Section 22-21-28. Increase in a hospital's bed capacity during the calendar year is assessed at the standard fee of $200.00 plus $5.00 each for the net gain in beds. No fee shall be refunded. All fees received by the State Board of Health under the provision of this article shall be paid into the State Treasury to the credit of the State Board of Health and shall be used for carrying out the provisions of this article. All licenses issued under this article shall expire on December 31 of the year in which it was issued. All licenses shall be on a form prescribed by said department, shall not be transferable or assignable, shall be issued only for the premises named in the application, shall be posted in a conspicuous place on the licensed premises and may be renewed from year to year upon application, investigation and payment of the required license fee, as in the case of procurement of the original license. All fees collected under this article are hereby appropriated for expenditure by the State Health Department. All hospitals which are accredited by the joint commission on accreditation of hospitals shall be deemed by the State Health Department to be licensable without further inspection or survey by the personnel of the State Department of Health. Further accreditation by the joint commission on accreditation of hospitals shall in no way relieve that hospital of the responsibility of applying for licensure and remitting the appropriate licensure fee as specified in this article. (Acts 1949, No. 530, p. 835, §5; Acts 1975, 3rd Ex. Sess., No. 140, p. 382, §2; Acts 1980, No. 80-642, p. 1213; Acts 1988, 1st Ex. Sess., No. 88-902, p. 470.)

**§22-21-25. License -- Issuance; suspension or revocation; new applications after revocation.**

(a) The State Board of Health is hereby authorized to issue licenses for the operation of hospitals which are found to comply with the provisions of this article and any regulations lawfully promulgated by the said State Board of Health.

(b) The State Board of Health is hereby authorized to suspend or revoke a license issued under this article on any of the following grounds:

(1) Violation of any of the provisions of this article or the rules and regulations issued pursuant thereto;

(2) Permitting, aiding or abetting the commission of any illegal act in such institution; or

(3) Conduct or practices deemed by the State Board of Health to be detrimental to the welfare of the patients of said institution.

(c) Before any such license issued under this article is suspended or revoked, written notice shall be given the licensee, stating the grounds of the complaint, and the date, time and place set for the hearing of said complaint, which date of hearing shall be not less than 30 days from the date of the notice. Such a notice shall be sent by registered or certified mail to the licensee at the address where the institution concerned is located. The licensee shall be entitled to be represented by legal counsel at the hearing.

(d) If a license is revoked as provided in this section, a new application for license shall be considered by the State Board of Health if, when and after the conditions upon which revocation was based have been corrected and evidence of this fact has been furnished. A new license shall then be granted after proper inspection has been made and all provisions of this article and rules and regulations promulgated under this article have been satisfied. (Acts 1949, No. 530, p. 835, §7.)

**§22-21-26. License -- Judicial review of suspension or revocation.** Any party aggrieved by a final decision or order of the Board of Health suspending or revoking a license is entitled to a review of such decision or order by taking an appeal to the circuit court of the county in which the hospital is located or is to be located. (Acts 1949, No. 530, p. 835, §11.)

**§22-21-27. Advisory board.**

(a) There shall be an advisory board of 12 members to assist in the establishment of rules, regulations and standards necessary to carry out the provisions of this article and to serve as consultants to the State Health Officer. The board shall meet at least twice each year and at the call of the

State Health Officer. The members of the board shall annually elect one of its members to serve as chairman.

(b) The advisory board shall be constituted in the following manner:

(1) Four representatives of hospitals, who shall be appointed by the Board of Trustees of the Alabama Hospital Association as follows:

a. One administrator of a governmental hospital;

b. One administrator of a nongovernmental nonprofit hospital;

c. One owner or administrator of a proprietary hospital; and

d. One member of a managing board of a nonprofit hospital;

(2) Three representatives who shall be doctors of medicine appointed by the Board of Censors of the Alabama State Medical Association;

(3) One representative who shall be a registered nurse appointed by the executive board of the Alabama State Nurses Association;

(4) One representative from the State Board of Human Resources to be appointed by the board;

(5) One registered pharmacist actively engaged in the practices of pharmacy in the State of Alabama, to be appointed by the Alabama State Board of Pharmacy;

(6) One member of the advisory board shall be appointed by the executive committee of the Alabama Nursing Home Association, who shall be the operator of a duly qualified licensed nursing home; and

(7) One member shall be appointed by the Alabama Hospice Association and said person shall vote only on issues relating to hospices.

Of the original representatives appointed by the Board of Trustees of the Alabama Hospital Association, one shall serve for three years, two shall serve for four years, and one shall serve for five years. One of the representatives appointed by the Board of Censors of the Alabama State Medical Association shall serve for two years, one shall serve for three years, and one shall serve for five years. The one representative appointed by

the Alabama State Nurses Association shall serve for four years. The one representative from the State Board of Human Resources shall serve for four years, and the one representative from the State Board of Pharmacy shall serve for four years. The representative appointed by the executive committee of the Alabama Nursing Home Association shall serve for five years. Thereafter, each new appointee shall serve for five years or until his successor is appointed; except, that in the case of a vacancy, the appointee shall serve for the remainder of the unexpired term. Any vacancy shall be filled by the original organization selecting said member.

(c) Members of the advisory board shall not be eligible to succeed themselves after they have served one full five-year term, but shall be eligible for reappointment if they have not served immediately preceding their reappointment.

(d) Members of the advisory board shall serve without compensation, but shall be entitled to reimbursement for expenses incurred in the performance of the duties of their office pursuant to Article 2 of Chapter 7 of Title 36. (Acts 1949, No. 530, p. 835, §9; Acts 1959, No. 134, p. 656; Acts 1991, No. 91-548, p. 1010, §1.)

**§22-21-28. Rules and regulations.**

(a) In the manner provided in this section, the State Board of Health, with the advice and after approval by the advisory board, shall have the power to make and enforce, and may modify, amend and rescind, reasonable rules and regulations governing the operation and conduct of hospitals as defined in Section 22-21-20. All such regulations shall set uniform minimum standards applicable alike to all hospitals of like kind and purpose in view of the type of institutional care being offered there and shall be confined to setting minimum standards of sanitation and equipment found to be necessary and prohibiting conduct and practices inimicable to the public interest and the public health. The board shall not have power to promulgate any regulation in conflict with law nor power to interfere with the internal government and operation of any hospital on matters of policy. Thirty days notice of any proposed amendment, rescission or new regulations shall be given in writing to all licensed hospitals of the date of such hearing and of the substance of any new regulation, amendment to or rescission of regulation proposed to be made. All hearings shall be joint hearings set by the Board of Health and the advisory board established in Section 22-21-27 at Montgomery, Alabama. At such hearing, any interested hospital or any member of the public may be heard.

(b) Any person affected by any regulation, amendment or rescission thereof may appeal consideration thereof to the

circuit court of the county of that person's residence or in which that person does business or to the Circuit Court of Montgomery County, within 30 days from the adoption of the same following the hearing provided in this section by giving security for costs and the filing of a petition with court, setting forth the interest of the appellant, the ruling complained of and the facts upon which the petitioner relies for relief. And upon appeal the question of the reasonableness of such regulation shall be a question of fact for the court to determine, and no presumption shall be indulged that the regulation adopted was and is a reasonable regulation.

(c) Regulations adopted under this section shall become effective upon the expiration of 30 days from the date of adoption, amendment or rescission or, if an appeal has been taken, upon the final disposition of the appeal. From any judgment of the circuit court in any case appealed to it, an appeal shall lie to the court of civil appeals of Alabama within 42 days from the date of entry of the judgment, in the same manner as other appeals are now authorized by law, and no presumption shall be indulged by the court of civil appeals as to the correctness of the trial court's finding of facts. (Acts 1949, No. 530, p. 835, §8.)

**§22-21-29. Inspections.**

(a) Every hospital licensed under this article shall be open to inspection to the extent authorized in this section by the State Board of Health, under rules as shall be promulgated by the board with the advice and consent of the advisory board. Nothing in this section shall authorize the board to inspect quarters therein occupied by members of any religious group or nurses engaged in work in such hospital or places of refuge for members of religious orders for whom care is provided, but any inspection shall be limited and confined to the parts and portions of such hospital as are used for the care and treatment of the patients and the general facilities for their care and treatment. No hospital shall, by reason of this section, be relieved from any other types of inspections authorized by law.

(b) All inspections undertaken by the State Board of Health shall be conducted without prior notice to the facility and its staff. Notwithstanding the foregoing, an inspection of a hospital or other health care facility, prior to its licensure, may be scheduled in advance. An employee or contract employee of the state shall not disclose in advance the date or the time of an inspection of a hospital or other health care facility to any person with a financial interest in any licensed health care facility, to any employee or agent of a licensed health care facility, to any consultant or contractor who performs services for or on behalf of licensed health care facilities, or to any person related by blood or

marriage to an owner, employee, agent, consultant, or contractor of a licensed health care facility. For purposes of this section, the term inspection shall include periodic and follow-up compliance inspections and surveys on behalf of the State Board of Health, complaint investigations and follow-up investigations conducted by the State Board of Health, and compliance inspections and surveys, complaint investigations, and follow-up visits conducted on behalf of the United States Department of Health and Human Services, Health Care Financing Administration, or its successors. The board may prescribe by rule exceptions to the prohibition where considerations of public health or safety make advance disclosure of inspection dates or times reasonable. Disclosure in advance of inspection dates when such disclosure is required or authorized pursuant to federal law or regulation shall not be a violation of this section. Scheduling inspections of hospitals or other health care facilities by the board at regular, periodic intervals which may be predictable shall not be a violation of this section.

(c) Any employee or contract employee of the state who discloses in advance the date or time of an inspection in violation of subsection (b) shall be guilty of a Class A misdemeanor. Any person who solicits an employee or contract employee of the state to disclose in advance the date or time of an inspection in violation of subsection (b) for the purpose of disclosing the information to others shall be guilty of a Class A misdemeanor. (Acts 1949, No. 530, p. 835, §6; Act 1997, No. 97-632, §1.)

**§22-21-30. Disclosure of information.**

Information received by the State Board of Health through on-site inspections conducted by the State Licensing Agency is subject to public disclosure and may be disclosed upon written request. Information received through means other than inspection will be treated as confidential and shall not be directed publicly except in a proceeding involving the question of licensure or revocation of license. (Acts 1949, No. 530, p. 835, §10; Acts 1975, 3rd Ex. Sess., No. 140, p. 383, §3.)

**§22-21-31. Practice of medicine, etc., not authorized; child-placing.** Nothing in this article shall be construed as authorizing any person to engage in any manner in the practice of medicine or any other profession nor to authorize any person to engage in the business of child-placing. Any child born in any such institution whose mother is unable to care for such child or any child who, for any reason, will be left destitute of parental support shall be reported to the State Department of Health and Human Resources or to any agency authorized or licensed by the State Department of Health and Human Resources to engage in child placing for such service as the child and the mother may require. In the rendering of such service, representatives of the State Department of Health

and Human Resources and agencies authorized or licensed by the State Department of Health and Human Resources shall have free access to visit the child and the mother concerned. (Acts 1949, No. 530, p. 835, §2; Acts 1962, Ex. Sess., No. 122, p. 157, §2.)

**§22-21-32.** Repealed by Acts 1977, 1st Ex. Sess., No. 82, p. 1509, §19, effective June 16, 1977.

**§22-21-33. Penalty for violation of article, etc.** Any individual establishing, conducting, managing or operating a hospital without first obtaining a license therefor as provided in this article or who shall violate any of the provisions of this article, or regulations promulgated thereunder, shall be guilty of a misdemeanor and, upon conviction, shall be punished by a fine of not to exceed $100.00 or by imprisonment in the county jail for a period not to exceed 90 days, or by both such fine and imprisonment in the discretion of the court. Any association, corporation or partnership operating a hospital in violation of any provisions of this article, or any regulation promulgated thereunder, shall be subject to the payment of a penalty of $25.00 per day for each day of such illegal operation, which may be recovered by the State Board of Health in an appropriate civil action. The State Board of Health may, upon the advice of the Attorney General, maintain an action in the name of the state for an injunction to restrain any state, county or local governmental unit, or any division, department, board or agency thereof, from operating, conducting or managing a hospital in violation of any provisions of this article, or any regulation promulgated thereunder. (Acts 1949, No. 530, p. 835, §12.)
**Author:**
**Statutory Authority:**
**History:**