Section 2

Regulation
Statement of purpose

R-39 Rev. 03/2012
(Title page)

IMPORTANT: Read instructions on back of last page (Certification Page) before completing this form. Failure to comply with instructions may cause disapproval of proposed Regulations

State of Connecticut
REGULATION
of

NAME OF AGENCY
Department of Public Health

Concerning

SUBJECT MATTER OF REGULATION
Short-term hospitals, special, hospice and Hospice Inpatient Facilities

Section 1. The regulations for Connecticut State Agencies is amended by adding section 19a-495-5a to 19a-495-5b as follows:

(NEW) Section 19a-495-5a. Applicability

(a) Any person, group of persons, association, organization, corporation, institution or agency, public or private, initially licensed prior to the effective date of this section under Connecticut General Statutes section 19a-495 to operate a hospice as defined in section 19-13-D1(b)(1)(c) of the Regulations of Connecticut State Agencies shall comply with the requirements set forth in sections 19a-495-5b of the Regulations of Connecticut State Agencies. Any such person or entity operating a hospice facility under said regulations may file an application with the Department for an initial license to operate a hospice inpatient facility in accordance with section 19a-495-6b of the Regulations of Connecticut State Agencies. Upon issuance of said license, the hospice facility shall comply with sections 19a-495-6a to 19a-495-6m, inclusive, of the Regulation of Connecticut State Agencies and shall immediately surrender its pre-existing license to operate a hospice facility.

(b) Any person, group of persons, association, organization, corporation, institution or agency, public or private applying for licensure to operate a hospice inpatient facility on or after the effective date of this section shall comply with sections 19a-495-6a to 19a-495-6m, inclusive, of the Regulation of Connecticut State Agencies.

Section 19a-495-5b. Short-term hospitals, special, hospice

(a) Physical plant:

1. General

(A) A free-standing hospice facility or a distinct hospice shall provide all the elements described in this section and shall be built in accordance with the construction requirements described in this section. Appropriate modifications or deletions in space and other physical requirements may be made to these requirements when services are permitted by the Department of Public Health to be shared or purchased, or waived because of a distinct unit's size. Distinct units of hospice facilities, including outpatient, in-patient and hospice-based care programs, shall meet the requirements described in this section, provided that the structure physically permits, the relevant services are provided at the facility and each facility's hospice program requirements are met. Services provided by a short-term hospital, general shall not be considered to constitute a hospice program of care unless such hospital

establishes a free-standing or distinct hospice unit to provide such services in which case the requirements of this section shall apply only to such free-standing or distinct hospice units.

(B) Construction plans and specifications, as well as program details, shall be submitted to and approved by the Department of Public Health prior to the start of construction.

(C) The buildings shall be of sound construction.

(D) Each application for license or renewal thereof shall be accompanied by a certificate of satisfactory inspection by the local fire marshal.

(E) Areas in which medical gases are used, shall meet the requirements of the National Fire Protection Association Standards 56A, 56B, 56F and such other rules, regulations, or standards which may apply.

(F) Equipment and furnishings shall be maintained in good condition, properly functioning and repaired or replaced when necessary.

(G) A short-term hospital, special, hospice shall secure licenses and any other required government authorization to provide hospice care services for terminally ill persons on a twenty-four hour basis in all settings including, but not limited to, a private home, nursing home and residential care home or specialized residence that provides supportive services and shall present to the department satisfactory evidence that the organization that provides the hospice services has the necessary qualified personnel to provide services in such settings.

2. Site.

(A) The site of new hospice facilities shall be away from uses detrimental to hospice patients such as industrial development and facilities that produce noise, air pollution, obnoxious odors, or toxic fumes.

(B) Adequate roads and walks shall be provided within the property lines to the appropriate entrances to serve patients, visitors, staff and for receiving goods and produce. The walks and roads shall be maintained in a clear and safe condition.

3. Access for persons who have a physical disability. Facilities should be accessible to and usable by persons who have a physical disability.

4. Design. The design of a hospice facility shall provide comfort, warmth and safety, privacy and dignity for the patients. Every possible accommodation shall be made to avoid creating an institutional atmosphere. The facility shall provide as homelike an atmosphere as practicable.

5. Waivers. Each service provided by a hospice facility shall conform to the appropriate requirements set forth in this section and each service shall be provided unless a written waiver is obtained from the Department of Public Health for good cause. A request for a waiver shall be in written form and accompanied by a narrative description of the hospice program. The waiver request shall identify the facility's needs and the rationale for such request.

6. Nursing unit.

(A) A nursing unit shall consist of not more than thirty beds.

(B) Each patient room shall meet the following requirements:

(i) No patient room entrance shall be located more than one hundred twenty feet from the nurses' station, clean workroom and soiled workroom;

(ii) Maximum room capacity shall be four patients;

(iii) To provide ample room for patients, families and visitors; the minimum room area exclusive of toilet rooms, closets, lockers, wardrobes, alcoves, or vestibules shall be one hundred twenty square feet in single-bedrooms and one hundred square feet per bed in multibedrooms. In multibedrooms, a clearance of three feet, ten inches shall be available at the foot of each bed and six feet between the beds to permit the passage of beds;

(iv) Each room shall have a window which can be opened without the use of tools. The windowsill shall not be higher than three feet above the finished floor. If insulated glass windows are not used, storm windows shall be installed. All windows used for ventilation shall be provided with screens;

(v) Each room shall be located on an outside wall of the building;

(vi) A nurse calling button shall be provided within easy access of each bed;

(vii) Room furnishings for each patient shall include an adjustable hospital bed with gatch spring, side rails, an enclosed bedside stand, an overbed table, an overbed light and a comfortable chair;

(viii) All floors shall be above the outside grade at the outside wall;

(ix) Each patient shall have a lockable wardrobe, locker or closet that is suitable for hanging full length garments and for storing personal effects;

(x) Each patient shall have access to a toilet room without entering the general corridor area. One toilet room shall serve no more than four beds and no more than two patient rooms. The toilet room shall contain a water closet, a lavatory, grab bar and an emergency call station; and

(xi) Cubicle curtains shall be installed for each bed in a multibedroom.

7. Service area requirements for each nursing unit shall provide:

(A) Storage space for office supplies;

(B) Hand washing facilities conveniently located to each nurses' station and drug distribution station;

(C) Charting facilities for nurses and doctors at each nurses' station;

(D) Individual closets or compartments for the safekeeping of personal effects of nursing personnel at each nurse's station;

(E) A multipurpose room for conference and consultation with a minimum floor space of one hundred square feet;

(F) A clean workroom that contains a work counter, hand washing sink, locked storage facilities, covered waste receptacles and ready access to an autoclave;

(G) A soiled workroom for receiving and cleanup of equipment which contains a clinical sink or equivalent flushing rim fixture, sink equipped for hand washing, work counter, covered waste receptacle, covered linen receptacles and locked storage facilities;

(H) A drug distribution station with a locked room for the storage of drugs and biological products. The drug storage room shall be located so as to be under the visual control of the nursing or pharmacy staff. The drug storage and preparation area shall be of adequate size for proper

storage, handling, preparation, and record keeping of all drugs and shall contain a work counter, refrigerator, hand sink with hot water, and necessary equipment such as a locked cabinet containers or drug carts;

(I) Clean linen storage in a separate closet or room sized to meet the needs of the unit. If a closed cart system is used, storage may be in an alcove;

(J) A nourishment station in a room which contains a stove, sink, equipment for serving nourishment between scheduled meals, refrigerator, storage cabinets, counter space and an icemaker-dispenser unit to provide ice for patients' service and treatment. This area is for patient, family and staff use and provisions shall be made for small appliance use and storage;

(K) An equipment storage room for I.V. stands, inhalators, air mattresses, walkers, and other patient equipment;

(L) An area out of the path of normal traffic that is adequate to accommodate two wheelchairs and one stretcher for the purpose of parking stretchers and wheelchairs;

(M) At least one bathtub or shower for each fifteen beds and one bathtub per nursing unit shall be of the free standing type with a clearance of three feet on three sides. Each tub or shower shall be located in an individual room or enclosure which provides space for a wheelchair and an attendant as well as dressing;

(N) A janitor's closet with a minimum size of twenty square feet which contains a floor receptor or service sink and locked storage space for housekeeping equipment and supplies;

(O) An isolation room for isolation medical treatment and control within the facility or through equivalent services in connection with a hospital. An isolation room located in a facility may be utilized as a regular patient room when not required for isolation purposes. Each such isolation room shall be a single patient room except as follows:

(i) Entrance shall be through a vestibule that contains a lavatory or sink equipped for hand washing, storage spaces for clean and soiled materials, and gowning facilities;

(ii) Provision shall be made for nursing observation of the patient from the vestibule;

(iii) A private toilet room containing a water closet and a bathtub or shower shall be provided for the exclusive use of the patient with direct entry from the patient bed area without passing through the vestibule;

(iv) A lavatory shall be provided for the exclusive use of the patient either in the patient room or in the private toilet room.

(P) A room for the examination of patients with a minimum floor area of one hundred ten square feet with a minimum dimension of nine feet excluding space for the vestibule, toilet, closets, and work counters, whether fixed or movable. The room shall contain a sink equipped for hand washing, work counter, storage facilities and a desk, counter or shelf space for writing;

(Q) A sitting room with not less than two hundred twenty-five square feet for every thirty beds;

(R) A patient dining area with fifteen square feet per patient to accommodate the total patient capacity of the facility which may be combined with the recreation area;

(S) A single recreation area of fifteen square feet per patient, an office for the director of arts and provisions for storage;

(T) An office for clergy and a chapel or space for religious purposes that shall be appropriately equipped and furnished;

(U) A separate room for the viewing of a deceased patient's body during bereavement until released to the responsible agent;

(V) A separate locked room or rooms for use as a pharmacy. This area shall be of adequate size to allow for efficient performance of all functions necessary for the provision of proper pharmaceutical services in the facility. The pharmacy shall be constructed so that it is not necessary to enter the pharmacy area to get to areas not directly related to the provision of pharmaceutical services. Proper lighting, a hand sink with hot water, refrigeration, humidity and separate temperature control in the pharmacy area shall be installed. Adequate space to accommodate specialized functions such as I.V. additive preparation, unit dose dispensing, drug information, manufacturing, as well as adequate storage space for bulk supplies, and office space for administrative functions shall be provided. Drug storage equipment such as a completely enclosed masonry room with a vault-type steel door, alarm system, safe, or locked cabinets as may be required to secure controlled substances and other drugs and biological products in compliance with applicable federal and state drug regulations, shall be located in the pharmacy area;

(W) A physical therapy area that includes a sink, cubicle curtains around treatment areas, storage space for supplies and equipment, a separate toilet room and office space;

(X) A dietary service area of adequate size that includes a breakdown and receiving area, storage space for four days food supply including cold storage, food preparation facilities with a lavatory, meal service facilities, dishwashing space in a room or alcove separate from food preparation and serving areas with commercial-type dishwashing equipment and space for receiving, scraping, sorting, and stacking soiled tableware, potwashing facilities, storage areas for supplies and equipment, waste storage facilities in a separate room easily accessible to the outside for direct pickup or disposal, office space(s) for dietitian and the food service manager, an icemaker-dispenser unit and a janitor's closet which contains a floor receptor or service sink and locked storage space for housekeeping equipment and supplies;

(Y) An entrance at grade level, sheltered from the weather, and able to accommodate wheelchairs;

(Z) A lobby with a reception and information counter or desk, waiting space, public toilet facilities, public telephones and a drinking fountain;

(AA) Offices for general business and storage, medical and financial records, and administrative and professional staffs with individual offices for administration, director of nursing, social services, and the medical director and separate spaces for private interviews relating to credit and admissions;

(BB) A medical records librarian's office or space, record review and dictating space, work area for sorting and recording, and a locked storage area for records;

(CC) A laundry area may be located either on the site of the facility or off the site of the facility for processing of linen;

(i) On-site processing requires the following:

(I) A laundry processing room with commercial-type equipment;

(II) A soiled linen receiving, holding and sorting room with hand washing facilities;

(III) Storage for laundry supplies;

(IV) Deep sink for soaking clothes;

(V) Clean linen storage, holding room and ironing area; and

(VI) Janitor's closet containing a floor receptor or service sink and locked storage space for housekeeping equipment and supplies.

(ii) Off-site processing requires the following:

(I) A soiled linen holding room with hand washing facilities; and

(II) A clean linen receiving, holding, inspection and storage room.

(iii) Each facility shall have a domestic type washer and dryer, located in a separate room, for patients' personal use.

(DD) A separate room or building for furnaces, boilers, electrical and mechanical equipment and building maintenance supplies;

(EE) A separate toilet room for employees of each sex with one water closet and one lavatory for each twenty employees of each sex;

(FF) Separate locker rooms for each sex containing individual lockers of adequate size for employee clothing and personal effects. The lockers shall be in an area divided from the water closets and lavatories; and

(GG) Separate employee dining space in the ratio of fifteen square feet per employee dining at one time that shall not be included in the space requirement for any other area.

8. Construction requirements.

(A) Fixtures such as drinking fountains, telephone booths, vending machines, and portable equipment shall be located so as not to restrict corridor traffic or reduce the corridor width.

(B) Room's containing bathtubs, showers, and water closets, for use by patients, shall be equipped with doors and hardware that provide access from the outside in any emergency.

(C) The minimum width of all doors to rooms needing access for beds or stretchers shall be three feet, eight inches. Doors to patients' toilet rooms and other rooms needing access for wheelchairs shall have a minimum width of two feet, ten inches.

(D) Doors on all openings between corridors and rooms or spaces subject to occupancy, except elevator doors, shall be of the swing type. Openings to showers, baths, patient toilets and other small wet-type areas not subject to fire hazard are exempt from this requirement.

(E) Doors, except those to spaces such as small closets that are not subject to occupancy, shall not swing into corridors in a manner that might obstruct traffic flow or reduce the corridor width.

(F) Windows and outer doors shall be provided with insect screens. Windows shall either be designed to prevent accidental falls when they are open, or shall be provided with security screens.

(G) Dumbwaiters, conveyors, and material handling systems shall not open directly into a corridor or exitway but shall open into a room enclosed by construction having a fire-resistance of not less than two hours and provided with class B one and one-half hour labeled fire doors. Service entrance doors to vertical shafts containing dumbwaiters, conveyors, and material handling systems shall be not less than class B one and one-half hour labeled fire doors. Where horizontal conveyors and material handling systems penetrate fire-rated walls or smoke partitions, such openings shall be provided with class D one and one-half hour labeled fire doors for two hour walls.

(H) Thresholds and expansion joint covers shall be made flush with the floor surface to facilitate use of wheelchairs and carts.

(I) Grab bars shall be provided at all patient toilets, showers, and tubs. The bars shall have one and one-half inch clearance to walls and shall have sufficient strength and anchorage to sustain a load of two-hundred fifty pounds.

(J) Recessed soap dishes or an adequate soap dispensing system shall be provided at showers and bath tubs.

(K) Mirrors shall not be installed at hand washing fixtures in food preparation areas or in clean and sterile supply areas.

(L) Paper towel and soap dispensers and covered waste receptacles shall be provided at all hand washing facilities used by patients, medical, nursing or food handling staff.

(M) Lavatories and hand washing facilities shall be securely anchored to withstand an applied vertical load of not less than two hundred and fifty pounds on the front of the fixture.

(N) Handrails shall be provided on both sides of the corridor in patient occupied areas at a height of thirty-two inches above the floor;

(O) Ceiling heights shall be as follows:

(i) Rooms shall be at least eight feet in height except that storage rooms, toilet rooms, and other minor rooms shall be at least seven feet, eight inches in height. Suspended tracks, rails, and pipes located in the path of normal traffic shall be at least six feet, eight inches above the floor;

(ii) Corridors shall be at least eight feet in height.

(P) Enclosures for stairways, elevator shafts and vestibules, chutes and other vertical shafts, boiler rooms, and storage rooms of one hundred square feet or greater area shall be of a construction having a fire-resistance rating of not less than two hours.

(Q) Interior finish materials shall comply with the flame spread limitations and the smoke production limitations of the State Fire Safety Code. If a separate underlayment is used with any floor finish materials, the underlayment and finish materials shall be tested as a unit or equivalent

provisions made to determine the effect of the underlayment on the flammability characteristics of the floor finish material.

(R) Building insulation materials, unless sealed on all sides and edges, shall have a flame spread rating of twenty-five or less and a smoke developed rating of one hundred and fifty or less when tested in accordance with ASTM Standard E 84.

(S) Toxicity of materials. Materials that do not generate toxic products of combustion shall be given preference in selecting insulation and furnishings.

(T) Elevators:

(i) All floors within the facility, other than the main entrance floor shall be accessible by elevator:

(I) At least one hospital-type elevator shall be installed where one to sixty patient beds are located on any floor other than the main entrance floor;

(II) At least two hospital-type elevators shall be installed where sixty-one to two hundred patient beds are located on any floor other than the main entrance floor, or where the major inpatient services are located on a floor other than those containing patient beds.

(ii) The cars of hospital-type elevators shall have inside dimensions that shall accommodate a patient bed and attendants.

9. Mechanical system requirements.

(A) General. Prior to the opening of the facility, all mechanical systems shall be tested, balanced and operated to ensure that the installation and performance of these systems conform to the requirements of the plans and specifications and are safe for patients and staff.

(B) Steam and hot water systems.

(i) Boilers shall have the capacity, based upon the net ratings published by the Institute of Boiler and Radiator Manufacturers, to supply the normal requirements of all systems and equipment. The number and arrangement of boilers shall be such that when one boiler breaks down or routine maintenance requires that one boiler be temporarily taken out of service, the capacity of the system shall be sufficient to provide hot water service for clinical, dietary, and patient use.

(ii) Boiler feed pumps, heating circulating pumps, condensate return pumps, and fuel oil pumps shall be connected and installed to provide normal and standby service.

(C) Air conditioning, heating and ventilating systems.

(i) All occupied areas shall be maintained at an inside temperature of seventy-five degrees Fahrenheit (twenty-four degrees Celsius) by heating and eighty degrees Fahrenheit (twenty-seven degrees Celsius) by cooling.

(ii) All air-supply and air-exhaust systems shall be mechanically operated. Fans serving exhaust systems shall be located at the discharge end of the system. The ventilation rates shown in table I are the minimum acceptable rates and shall not be construed as precluding the use of higher ventilation rates.

(iii) Outdoor intakes shall be located as far as practical from exhaust outlets of ventilating systems, combustion equipment stack, medical-surgical vacuum systems, plumbing vents stacks, or areas that may collect vehicular exhaust and other noxious fumes. The bottom of outdoor air intakes serving central systems shall be located as high as practical.

(iv) Corridor plenums shall not be used to supply air to or exhaust air from any room.

TABLE I
General Pressure Relationships and Ventilation
Of Certain Hospice Areas

Area Designation	Pressure Relationship to Adjacent Areas	Minimum Air Changes of Outdoor Air per Hour Supplied to Room	Minimum Total Air Changes Per Hour Supplied to Room	All Air Exhausted Directly to Outdoors	Recirculated Within Room units
Patient Room	E	2	2	Optional	Optional
Patient Room Corridor	E	2	4	Optional	Optional
Isolation Room	E	2	6	Yes	Yes
Isolation Room Alcove or Anteroom	E	2	10	Yes	No
Examination Room	E	2	6	Optional	Optional
Medication Room	P	2	4	Optional	Optional
Pharmacy	P	2	4	Optional	Optional
Treatment Room	E	2	6	Optional	Optional
X-Ray, Treatment Room	E	2	6	Optional	Optional
Physical Therapy	N	2	6	Optional	Optional
Soiled Workroom	N	2	10	Yes	No
Clean Workroom	P	2	4	Optional	Optional
Workroom	N	2	10	Yes	No
Viewing Room	N	Optional	10	Yes	No
Toilet Room	N	Optional	10	Yes	No
Bedpan Room	N	Optional	10	Yes	No
Bathroom	N	Optional	10	Yes	No
Janitor's closet	N	Optional	10	Yes	No
Sterilizer Equipment Room	N	Optional	10	Yes	No
Linen and Trash	N	Optional	10	Yes	No

P=Positive
N=Negative
E=Equal

(D) Plumbing and other piping systems.

(i) Plumbing fixtures.

(I) The water supply spout for lavatories and sinks in patient care areas shall be mounted so that its discharge point is a minimum distance of five inches above the rim of the fixture. All fixtures used by medical and nursing staff and all lavatories used by food handlers shall be trimmed with valves that can be operated without the use of hands.

(II) Shower bases and tubs shall provide nonslip surfaces for standing patients.

(ii) Water supply systems.

(I) Systems shall be designed to supply water at sufficient pressure to operate all fixtures and equipment during maximum demand periods.

(II) Each water service main, branch main, riser, and branch to a group fixture shall be valved. Stop valves shall be provided at each fixture.

(III) Backflow preventers shall be installed on hose bibbs, laboratory sinks, janitors' sinks, bedpan flushing attachments, equipment that can be directly piped, and on all other fixtures to which hoses or tubing can be attached.

(IV) Water distribution systems shall be arranged to provide hot water at each hot water outlet at all times. Hot water at shower, bathing and hand washing facilities personal use shall not exceed one hundred twenty degrees Fahrenheit (forty nine degrees Celsius.)

(iii) Hot water heaters and tanks.

(I) The hot water heating equipment shall have sufficient capacity to supply water at the temperatures and amounts indicated below. Water temperatures to be taken at hot water point of use or inlet to processing equipment.

Use	Clinical	Dietary	Laundry
Gallons (per hour Per Bed)	6 ½	4	4 ½
Temperature °(F)	110-120°	Wash 160°	180°
°(C)	43-49°	71°	82°
°(F)		Rinse 180°	
°(C)		82°	

(E) Medical gas and vacuum systems.

(i) Nonflammable medical gas systems. Nonflammable medical gas system installations shall be in accordance with the requirements of National Fire Protection Association Standards 56 F and such other rules, regulations or standards that may apply.

(ii) Clinical vacuum (suction) systems. Clinical vacuum system installations shall be in accordance with the requirements of National Fire Protection Association Standards 56 F and such other rules, regulations or standards that may apply. The vacuum system may either be a central system or a portable system.

(iii) One outlet of oxygen and one of vacuum of each bed shall be provided in each patient room.

10. Electrical system requirements.

(A) General. All material including equipment, conductors, controls, and signaling devices shall be installed to provide a complete electrical system and shall comply with most recent available standards of Underwriters Laboratories, Inc., or other nationally recognized standards that may apply.

(B) Switchboards and power panels. Circuit breakers or fusible switches that provide disconnecting means and overcurrent protection for

conductors connected to switchboard's and panelboards shall be enclosed or guarded to provide a dead-front type of assembly. The main switchboard shall be located in a separate enclosure accessible only to authorized persons. The switchboards shall be convenient for use, readily accessible for maintenance, clear of traffic lanes, and in a dry ventilated space free of corrosive fumes or gases. Overload protective devices shall be suitable for operating properly in the ambient temperature conditions.

(C) Panelboards. Panelboards serving lighting and appliance circuits shall be located on the same floor as the circuits the panelboards serve. This requirement does not apply to emergency system circuits.

(D) Lighting.

(i) All spaces occupied by people, machinery, and equipment within buildings, approaches to buildings, and parking lots shall have lighting.

(ii) Patients' rooms shall have general lighting and night lighting. A reading light shall be provided for each patient. General room illuminaries shall be switched at the entrance to the patient room. All switches for control of lighting in patient areas shall be of the quiet operating type. Night light circuits for each nursing unit shall be controlled at the nurses' stations.

(E) Receptacles or outlets.

(i) Patients' rooms. Each patient room shall have duplex grounding type receptacles as follows: Three duplex for each bed; two on one side and one on opposite side of the head of each bed; one for television and one on another wall.

(ii) Corridors. Duplex receptacles for general use shall be installed approximately fifty feet apart in all corridors and within twenty-five feet of ends of corridors.

(F) Nurses' calling system. In general patient areas, each room shall be served by at least one calling station and each bed shall be provided with a call button. Two call buttons serving adjacent beds may be served by one calling station. Calls shall register with floor staff and shall actuate a visible signal in the corridor at the patient's door, in the clean workroom, the soiled workroom, and the nourishment station of the nursing unit. In multi-corridor nursing units, additional visible signals shall be installed at corridor intersections. In rooms containing two or more calling stations, indicating lights shall be provided at each station. Nurses' calling systems shall be audio visual and provide two-way voice communication and shall be equipped with an indicating light at each calling station, which lights and remains lighted as long as the voice circuit is operating. A nurses' call emergency button shall be provided at each patient's toilet, bath, shower room, dining room and sitting room.

(G) Emergency electric service.

(i) To provide electricity during an interruption of the normal electric supply, an emergency source of electricity shall be provided and connected to certain circuits for lighting and power. The source of this emergency electric service shall be an emergency generating set including the prime mover and generator which is

located on the premises and shall be reserved exclusively for supplying the emergency electrical system.

(ii) The emergency generating set shall provide electricity:

(I) To illuminate means of egress and exit signs and directional signs;

(II) To operate all essential alarm systems including fire alarms activated at manual stations, water flow alarm devices of sprinkler system if electrically operated, fire and smoke detecting systems, and alarms required for non-flammable medical gas systems;

(III) To operate paging or speaker systems intended for communication during emergency;

(IV) For the general illumination and selected receptacles in the vicinity of the generator set;

(V) For specific task illumination and selected receptacles in medicine dispensing areas; treatment rooms; and nurses' stations;

(VI) To one duplex receptacle at each patient bed;

(VII) To the nurses' calling system;

(VIII) To operate equipment necessary for maintaining telephone service;

(IX) To the fire pump, if any; and

(X) To circuits that serve necessary equipment as follows:

(a) Equipment for heating patient occupied rooms, except that service for heating of general patient rooms shall not be required if the facility is served by two or more electrical services supplied from separate generators or a utility distribution network having multiple power input sources and arranged to provide mechanical and electrical separation so that a fault between the facility and the generating sources shall not likely cause an interruption of the facility service feeders;

(b) Elevator service shall reach every patient floor. Transfer devices shall be provided to allow temporary operation of any elevator for the release of persons who may be trapped between floors.

(c) Central suction systems serving medical functions;

(d) Laboratory fume hoods.

(H) The connection to the emergency electric services shall be of the delayed automatic type except for heating, ventilation, and elevators which may be either delayed automatic or manual.

(i) The emergency electrical system shall ensure that after interruption of the normal electric power supply the generator is brought to full voltage and frequency and connected within ten seconds through one or more primary automatic transfer switches to emergency lighting systems; alarm systems; blood banks; nurses' calling systems; equipment necessary for maintaining telephone service; and task illumination and receptacles in operating, delivery, emergency, recovery, and

cardiac catherization rooms, intensive care nursing areas, nurseries, and other critical patient areas. All other lighting and equipment required to be connected to the emergency system shall either be connected through the primary automatic transfer switches, as described in this subparagraph or through other automatic or manual transfer switches. Receptacles connected to the emergency system shall be distinctively marked. Storage-battery-powered lights, provided to augment the emergency lighting or for continuity of lighting during the interim of transfer switching immediately following an interruption of the normal service supply, shall not be used as a substitute for the requirement of a generator. Where stored fuel is required for emergency generator operation, the storage capacity shall be sufficient for not less than forty-eight hour continuous operation. When the generator is operated by fuel which is normally piped underground to the site from a utility distribution system, fuel storage facilities on the site shall not be required.

11. Maintenance of systems and equipment. All electrical, gas, life safety, life support and critical systems shall be tested to ensure satisfactory performance prior to placing them into service and tested annually thereafter. Permanent records of all tests shall be maintained.

(b) Administration.

(1) The hospice shall be managed by a governing board with full legal authority and responsibility for the conduct of the hospice and the quality of medical care provided at the facility. Duties of the governing board shall include, but not be limited to:

(A) Adoption of the following in writing and upon adoption enforcing compliance with:

(i) admission criteria defining eligibility for hospice services;

(ii) guidelines for community relations;

(iii) a patient bill of rights;

(iv) medical by-laws after considering the recommendations, if any, of the medical staff;

(v) rules and by-laws which include the following:

(I) the purpose of the hospice;

(II) annual review of the rules and by-laws, which shall be dated and signed by the chairperson of the board;

(III) the powers and duties of the officers and committees of the governing body;

(IV) the qualifications, method of selection and terms of office of members and chairperson of committees;

(V) a mechanism for approval of the appointments to the medical staff;

(VI) qualifications for appointment to the medical staff based upon background, competence, and adherence to the ethics of the profession;

(VII) a schedule of at least ten regular meetings per calendar year; and

(VIII) a specific policy governing conflict of interest of members.

(B) Establishment of a joint practice committee composed of representatives of medical staff, nursing staff, pharmacy staff, social work staff, arts and pastoral care staff, volunteer staff and the administrator or the administrator's designee.

(C) Appointment of the administrator who shall have one of the following:

(i) completed postgraduate training approved by the Association of University Programs in hospital administration;

(ii) attained three years experience as an assistant administrator;

(iii) served three years as a hospice administrator under a state approved hospice program; and

(iv) qualified by other experience approved by the Department of Public Health upon written application to the commissioner.

(2) The administrator shall be responsible to the governing board for the management and operation of the hospice and for the employment of personnel. The administrator shall attend meetings of the governing board and of the medical staff, employ personnel of good character and suitable temperament in sufficient numbers to provide satisfactory care for the patients.

(3) Outside services or resources as required by the facility or ordered by the physician shall be utilized only pursuant to written agreements. The responsibilities, function and terms of each agreement, including financial arrangements and charges, shall be specified therein and signed and dated by the chairperson of the board, or administrator of the hospice and the person or duly authorized official of the agency providing the service or resource.

(4) Any person or his family may request hospice in-patient, out-patient and hospice-based home care services with the concurrence of a member of the medical staff of the facility.

(c) Medical staff.

(1) There shall be a medical staff of not fewer than five physicians, one of whom shall serve as a chief, president, or medical director of the medical staff and all of whom shall be licensed to practice medicine and surgery in Connecticut. The medical staff shall be composed of active medical staff, associate medical staff, courtesy medical staff, consulting medical staff and honorary medical staff.

(2) The medical staff shall adopt written by-laws and rules governing its own activities not inconsistent with any rule, regulation, or policy of the governing board, which by-laws and rules shall not become effective until approved by the governing board and shall be subject to rescission by the governing board, which shall include:

(A) requirements for admission to staff and for the delineation and retention of clinical privileges;

(B) method of control of clinical work, including written consultations for all clinical services that shall be properly entered in the patient's chart;

(C) analysis, review and evaluation of clinical practices within hospice in-patient, out-patient and hospice-based home care programs, to promote and maintain high quality care;

(D) a framework to ensure twenty-four hour, seven-day-a-week on-call availability, including physician home visits, and eight-hour-a-day on-site medical staff coverage;

(E) provision for monthly staff conferences unless clinical groups hold departmental or service conferences at least monthly, then general staff

conferences shall be held at least four times each year, and each active staff member shall attend not less than ten departmental or general staff meetings or a combination thereof each year;

(F) establishment of committees including infection control, safety, quality assurance, pharmacy and therapeutics, medical record audit, patient care, and others as necessary; and

(G) procedures for recommending appointments to the medical staff, hearing complaints regarding the conduct of members and referring the same, with recommendations, to the governing board.

(3) Any patient's primary care community physician who is not a member of the hospice medical staff may request hospice services for the patient with the concurrence of a hospice medical staff member.

(4) Medical staff and departmental meetings shall be attended by at least fifty percent of the active staff members to be counted toward the mandatory meeting quotas. Minutes and a record of attendance shall be kept.

(5) There shall be a department of medicine under the direction of a physician licensed to practice medicine and surgery in Connecticut, who shall be responsible for supervising the quality of medical service.

(6) The chief, president, or medical director of the medical staff shall supervise the bereavement team which shall consist of himself, a consulting psychiatrist and one representative from each of the following services: volunteer, pastoral care, arts, social work and nursing.

(7) The medical staff shall provide and participate in a continuing program of professional education which shall include hospice-based home care programs scheduled on a regular basis with appropriate documentation of these activities.

(d) Medical records.

(1) There shall be a medical record department with adequate space, equipment and qualified personnel including a medical record librarian or a person with training, experience and consultation from a medical record librarian.

(2) A medical record shall be maintained for every individual who is evaluated or treated as a hospice in-patient, out-patient or who received patient services in a hospice-based home care program.

(3) An in-patient record shall be started at the time of admission with identification, date, and a nurse's notation of condition on admission. To the in-patient record shall be added immediately an admission note and orders by the attending member of the active medical staff. A complete history and physical examination shall be recorded by a staff physician within twenty-four hours of admission, unless the patient is being followed by his primary physician who performed the patient's last history and physical examination within forty-eight hours and the referral to the hospice program is made within the same institution. A problem oriented medical record shall be completed by the primary care nurse within twenty-four hours of admission.

(4) All medical records shall be prepared accurately and physicians' entries completed promptly with sufficient information and progress notes to justify the diagnosis and warrant the treatment and palliation. Doctors' orders, nurses' notes and notes from other disciplines, shall be kept current in a professional manner and all entries shall be signed with a legally acceptable signature by the person responsible for making the order or note.

(5) The medical records shall be kept confidential and secured. Written consent of the patient or his legally appointed representative shall be required for release of medical information except as provided in subsection (t) of this section.

(6) The medical records shall be filed and stored in a manner providing easy retrievability and shall be kept for not less than twenty-five years after discharge of patients, except that original medical records may be destroyed sooner if they are microfilmed by a process approved by the state Department of Public Health.

(7) Completion of the medical records shall be accomplished within one day after discharge to a hospice-based home care program or within seven days of death.

(8) Persistent failure by a physician to maintain proper records of his patients, promptly prepared and completed, shall constitute grounds for suspending or withdrawing his medical staff privileges.

(e) Nursing Service.

(1) The nursing service who shall be directed by the director of hospice patient care services shall be a licensed registered nurse with baccalaureate degree in nursing and an active Connecticut license, and who is further qualified by one of the following:

(A) a master's degree from a program approved by the National League of Nursing or the American Public Health Association with not less than two (2) years' full-time clinical experience under qualified supervision, in a hospice or home health care agency related community health program that included care of the sick; and

(B) not less than four (4) years of full-time clinical experience in nursing, at least two (2) of which were under qualified supervision in a hospice or home health care agency or community health program that included care of the sick.

(2) A registered nurse with a baccalaureate degree in nursing and an active Connecticut license and one of the following shall serve as a supervisor of hospice in-patient, out-patient and hospice-based home care program under the direction of the director of hospice patient care services:

(A) a master's degree from a program approved by the National League for Nursing or the American Public Health Association with not less than two (2) years' full-time clinical experience under qualified supervision, one of which shall be in a health care institution and one of which shall be in a hospice or home health care agency or a related community health program; and

(B) not less than four (4) years' full-time clinical experience in nursing under qualified supervision, one of which shall be in a health care institution and one of which shall be in a hospice or home health care agency or related community health program.

(3) The ratio of patients to registered nurses in the hospice shall not be less than one nurse to six patients per eight hour shift.

(4) The ratio of all nursing staff and nurses aides to patients shall not be less than one nurse or nurse aide to three patients.

(5) An organizational plan of the nursing service shall be established that shall delineate its mechanism for cooperative planning and decision making.

(6) Written nursing care and administrative policies and procedures shall be developed to provide the nursing staff with practical methods of meeting its

responsibilities and achieving projected goals. Policies shall include, but not be limited to, the following:

(A) assigning the nursing care of patients to a primary care provider who develops a written pertinent care plan;

(B) standardized procedures for evaluation and study;

(C) a program of systematic professional and administrative review and evaluation of the services' effectiveness in relation to stated objectives;

(D) patient and family teaching programs;

(E) the development and implementation of staffing patterns that shall ensure efficient performance of departmental activities; and

(F) participation in the joint practice committee for the improvement of patient care including equal representation of practicing nurses and physicians, and continuous redefining of the scope of medical and nursing practice in the light of experience and patient care needs.

(7) There shall be staff development programs and educational opportunities for nursing personnel that include orientation and in-service education.

(f) Pharmaceutical service.

(1) The facility shall maintain an organized pharmaceutical service that is conducted in accordance with current standards of practice and all applicable laws and regulations.

(2) The pharmaceutical service shall be directed by a licensed pharmacist trained in the specialized functions of institutional pharmacy who shall serve the institution:

(A) on a full-time basis in a free-standing facility; and

(B) in a distinct unit identified as hospice on a part-time basis consonant with the size and scope of services of the institution.

(3) The scope of pharmaceutical services shall be consistent with the drug therapy needs of the patients as determined by the medical staff.

(4) There shall be an active medical staff committee, composed of a physician, the director of pharmacy, the director of patient care services, and a representative from administration that shall serve in an advisory capacity to the professional staff on matters relating to drugs and drug practices. Specific functions of this committee, which shall meet at least quarterly, shall include:

(A) development of board professional policies regarding the evaluation, selection, procurement, distribution, use, safe-practices and other matters pertinent to drugs and biological products in the facilities;

(B) development of basic formulary system of drugs for use in the facilities;

(C) monitoring and reporting adverse drug reactions in the facility, and introducing proper measures to minimize their incidence;

(D) reviewing and analyzing errors in the administration of drugs and biological products in the facility and taking appropriate action to minimize the recurrence of such incidents; and

(E) determining drug-use patterns and assisting in the setting of drug-use criteria relative to the facility's drug utilization review program.

(5) There shall be a current, written policy and procedures manual approved by the medical staff, pertaining to the drug and biological control system in the facility.

(g) Social work service.

(1) There shall be a written plan with clearly defined written policies governing the delivery of social work services in the hospice in-patient, out-patient and

hospice-based home care program which shall include a procedure for reporting problem areas to the administrator, recommended solutions, and identifying actions taken. These policies shall incorporate the current standards, guidelines, and code of ethics determined by the National Association of Social Workers. The person having responsibility for the direction and supervision of the delivery of such services shall be a social worker with a master's degree from a school accredited by the Council of Social Work Education, who has not less than four years social work experience in a health care setting including one year in a supervisory capacity.

(2) The social work staff may include baccalaureate social workers with at least one year of social work experience in a health care setting.

(3) There shall be a social work department with an adequate staff to meet the medically related social and emotional needs of the patient and family.

(4) Social work services shall be provided in accordance with the plan for treatment. The social worker shall assist and work with the interdisciplinary team in identifying significant social and emotional factors related to care. The scope of social work services shall include: assisting in pre-admission and discharge planning; conducting medico-social assessment; counseling the patient and family on an individual and group basis; identifying, utilizing, and working to develop appropriate community resources; and maintaining adequate records relating to social work services that shall be included in the patient's medical record.

(5) There shall be continuing staff development programs and educational opportunities for social work personnel that include orientation and in-service education.

(h) Pastoral care service.

(1) The hospice shall have adequate pastoral care services in the in-patient, outpatient and hospice-bed home care program, twenty-four hour on-call availability, and a well defined written plan and policies for pastoral care services available at the request of the patient.

(2) The plan for pastoral care services shall ensure the supervision of the delivery of such services by an ordained and a qualified individual with a graduate theological degree and at least five years pastoral and clinical experience. The method for providing pastoral care to a patient or family shall be planned and developed in consultation with representatives of administration, medical staff, nursing staff, other departments and services that are involved in direct patient care, and representatives of the community. The director of pastoral care services shall be considered a member of the health care team, and may participate in all staff meetings.

(3) There shall be continuing staff development programs and educational opportunities for the pastoral care staff including orientation and in-service education.

(i) The arts.

(1) The hospice shall provide extensive opportunities for experiences in the arts to the patients and families and for staff consultation as appropriate. The arts shall be available to hospice patients both on a scheduled and intermittent basis. Designated arts staff members who are providing such experiences shall be available on a scheduled on-call basis.

(2) These artistic experiences shall be directed and coordinated by a qualified representative of the arts with a graduate degree and clinical experience in a hospital based setting in the arts or pastoral care and not less than five years supervisory experience in the arts and education who, in consultation with hospice staff members and community artist representatives, shall define the need, choose an appropriate art form and select the artist or means to provide this experience.

(3) The director of the arts shall be considered a full-fledged member of the health care team, with participation in all staff meetings. Written policies for the arts shall be developed and reviewed at least annually. Adequate records relating to artistic services rendered shall be included in the patient's medical record.

(4) The arts staff shall complete a program of orientation to hospice and shall have appropriate in-service education programs on a quarterly basis.

(j) Volunteer service.

(1) A director of volunteers shall be employed full-time to plan, organize and direct a comprehensive volunteer services program for the in-patient, out-patient and hospice-based home care program. The director shall have a bachelor's degree in psychology, sociology, therapeutic recreation, or a related field and one year of employment in a supervisory capacity in a volunteer services program or an associate's degree and three years of supervisory experience in a volunteer services program.

(2) The director shall:

(A) Plan, direct and implement the recruitment of volunteers;

(B) orient and provide for a program of training which includes, direct involvement, on-call service and staff support;

(C) evaluate performances and effectiveness of each volunteer annually;

(D) periodically review and revise policies and procedures; and

(E) coordinate the utilization of volunteers with other directors as appropriate.

(3) There shall be continuing staff development programs and educational opportunities for the volunteer services staff to include at least the following: orientation and in-service education.

(k) Diagnostic and palliative services. Services, under competent medical supervision, shall be provided for necessary diagnostic and palliative procedures to meet the needs of the hospice in-patient, out-patient, and hospice-based home care program. This shall include the services of a clinical laboratory and radiological services which shall meet all applicable standards of the Department of Public Health. In addition there may be written agreements for other services including blood bank and pathological services as determined by patient needs. All contracts shall specify twenty-four hour on-call availability.

(l) Respiratory care services. There shall be a written plan with clearly defined written policies and procedures governing the delivery of respiratory care services that shall include a procedure for reporting problem areas to the administrator, recommendations, solutions, and identifying action taken. Services, under direct medical supervision, shall be provided as necessary to meet the needs of the hospice programs, which shall meet all applicable standards of the Department of Public Health. Any contract for such services shall specify twenty-four hour on-call availability for hospice in-patient, out-patient, and hospice-based home care programs.

(m) Specialized rehabilitative services. There shall be a written plan with clearly defined written policies and procedures governing the delivery of rehabilitative services that shall include a procedure for reporting problem areas to the administrator, recommendations, solutions, and identifying action taken. Any contracts for such services shall specify twenty-four hour on-call availability for hospice in-patient, out-patient, and hospice-based home care programs.

(n) Dietary service.

(1) There shall be an organized dietetic service, directed by a full-time food service supervisor. The food service supervisor shall be an experienced cook knowledgeable in food service administration and therapeutic diets. The service shall employ an adequate number of individuals to perform its duties and responsibilities.

(2) There shall be written policies and procedures governing all dietetic activities.

(3) The service shall have at least one qualified part-time certified dietitian-nutritionist, with a baccalaureate degree and major studies in food and nutrition who is qualified for membership in and registration by the Commission on Dietetic Registration. The administration of the nutritional aspects of patient care shall be under the direction of the dietitian whose duties shall include:

(A) recording nutritional histories of in-patients;

(B) interviewing patients regarding their food habits and preferences;

(C) counseling patient and family concerning normal or modified diets and encouraging patients to participate in planning their own modified diets and instructing patient and family in food preparation; and

(D) participating in appropriate hospice rounds and medical conferences;

(E) coordinating activities with the food service supervisor.

(4) Educational programs shall be offered to dietetic service employees including orientation, on-the-job training, personal hygiene, the inspection, handling, preparation, and serving of food, and the proper cleaning and safe operation of equipment.

(o) Hospice-based home care program.

(1) The health care services of the hospice-based home care program shall be in accordance with accepted standards of practice, applicable law and hospice policies and shall be provided by the interdisciplinary team as defined in section 19a-495-6a(a)(21) of the Regulations of Connecticut State Agencies. The program of care shall provide medical and health care services for the palliative and supportive care and treatment only for the terminally ill and their families. The hospice-based home care program encompasses the physical, social, psychological and spiritual needs of the patient and family and consists of services on a twenty-four hour basis, seven days per week. The services of hospice-based home care program shall include bereavement service, medical nursing, homemaker home health aide, pharmaceutical, dietary, pastoral care, arts, volunteers, diagnostic and palliative, social work, respiratory care, specialized rehabilitative, infection control and, as needed, in-patient and out-patient hospice services shall be available to hospice-based home care patients and their families.

(2) An organizational structure designed to effectively implement the requirements as described in subdivision (1) of this subsection. The medical director and the director of patient care services shall be vested with the overall coordination of the hospice-based home care program. The hospice-based home care

program shall have a supervisor who shall meet the requirements of subparagraphs (e)(2)(A) or (B) of this section.

(3) The patient's primary care community physician, who is not a member of the hospice medical staff, shall be granted the privilege of requesting services provided by the hospice-based home care program in concurrence with a member of the hospice medical staff and on condition that the physician shall continue to be the primary care provider for the patient while the patient is at home under the auspices of the home care program.

(4) There shall be twenty-four hour, seven-day-a-week on-call availability of the hospice medical director or his designee and the hospice home care nurse whether or not community service agency nurses are available. All physicians who provide medical services to patients in the hospice-based home care program, whether or not such physicians are members of the hospice medical staff, shall be evaluated as part of the regular hospice medical care evaluation program.

(5) There shall be a written policy and procedure manual implementing the objectives of the hospice-based home care program that shall include a description of the scope of services, criteria for admission and discharge, follow-up policies, and uniform standards to be adopted by the patient's primary care community physician.

(6) The hospice-based home care program shall have necessary personnel to meet the needs of patients, including: licensed registered nurses, licensed practical nurses, and homemaker-home health aides. Personnel assigned by community service agencies to provide services to the program's patients shall meet qualification standards equivalent to those required by hospice for employees in its home care program. When volunteer services are used, volunteers shall be trained and supervised by the hospice director of volunteers or other appropriate hospice directors, and those who provide professional services shall meet the requirements of qualification and performance applied to paid staff and functions. Hospice-based home care program personnel shall be involved in educational programs relating to their activities, including orientation, regularly-scheduled, in-service training programs, workshops, institutes, or continuing education courses to the same extent as other hospice personnel.

(7) There shall be a program of systematic, professional and administrative review and evaluation of the program's effectiveness in relation to its stated objectives.

(8) An accurate medical record shall be maintained for every patient receiving services provided through the home care program.

(9) Arrangements for the provision of basic or major services by a participating community agency or individual provider shall be documented by means of a written agreement or contract. All hospice services available to patients in the in-patient and out-patient program shall be readily available to the home care program patients.

(p) Infection control.

(1) Each hospice shall develop an infection prevention, surveillance and control program that shall have as its purpose the protection of patient, family and personnel from hospice or community associated infections in patients admitted to the hospice in-patient, out-patient, and home care program.

(2) The infection prevention, surveillance, and control program of each hospice shall be approved by the medical staff and adopted by the governing board. The program shall become part of the by-laws of the medical staff.

(3) A hospice infection control committee shall be established to supervise infection control and report on its activities with recommendations on a regular basis to the medical director. The membership of the committee shall include a physician who shall be the chairperson, a representative from nursing service, hospital administration, pharmacy, dietary service, laundry, housekeeping and the local health director.

(4) The infection control committee shall:
   - (A) adopt working definitions of hospice-associated infections;
   - (B) develop standards for surveillance of incidents of hospice-related infection and conditions predisposing patients to infection;
   - (C) monitor and report infections in all patients, including patients in the home care program, and environmental conditions with infection potential;
   - (D) evaluate the potential for environmental infection, including identification whenever possible of hospice-associated infections and periodic review of the clinical use of antibiotics in patient care; and
   - (E) develop preventive measures including aseptic techniques, isolation policy, and a personnel health program.

(5) There shall be an individual employed by the hospice who is qualified by education or experience in infection prevention, surveillance, and control to conduct these aspects of the program as directed by the infection control committee. The employee shall be directly responsible to, and be a member of, the infection control committee. The employee shall make a monthly written report to the committee at its monthly meeting.

(6) The infections control committee shall meet at least monthly and:
   - (A) review information obtained from day-to-day surveillance activities of the program;
   - (B) review and revise existing standards; and
   - (C) report to the medical director.

(7) There shall be regular in-service education programs regarding infection prevention, surveillance and control for hospice personnel. Documentation of these programs shall be available to the Department of Public Health for review.

(q) General.

(1) The hospice shall have an adequate laundry service, housekeeping and maintenance services.

(2) Proper heat, hot water, lighting and ventilation shall be maintained at all times.

(3) The hospice shall ensure the health, comfort and safety of the patients at all times.

(4) When a patient ceases to breathe and has no detectable pulse or blood pressure, the body shall be moved to the bereavement room in the same institution pending completion of the medical certification portion of the death certificate by a person authorized to complete such medical certification in accordance with section 7-62b of the Connecticut General Statutes. The facility shall make available a room that shall provide for the dignified holding of the body of the deceased person where the body of the deceased person

shall not be exposed to the view of patients or visitors, but where the family and friends of the deceased may view the body.

(r) Out-patient services.

(1) The hospice out-patient service shall meet the same standards of quality as applied to in-patient care, considering the inherent differences between in-patients and out-patients with respect to their needs and modes of treatment.

(2) The out-patient service shall be provided with services and personnel necessary to meet the needs of patient and family.

(3) There shall be a policy and procedure manual developed for the effective implementation of the objectives of the out-patient service including criteria for eligibility for out-patient care.

(4) There shall be a program of systematic professional and administrative review and evaluation of the service's effectiveness.

(5) Facilities for the out-patient service shall be conducive to the effective care of the patient.

(6) An accurate medical record shall be maintained for every patient receiving care provided by the out-patient service.

(s) Emergencies: Provision shall be made to maintain essential services during emergency situations.

(t) Record availability: It is an explicit condition for the initial issuance of or the retention or renewal of a license to any person to operate and maintain a hospice that all records, memos and reports, medical or otherwise be maintained on the premises of the facility and that said records shall be subject to inspection review and copying by the Department of Public Health upon demand, including personnel and payroll records. Failure to grant access to the Department of Public Health shall result in the denial of, revocation of, or a determination not to renew the license.

Section 2. The regulations for Connecticut State Agencies are amended by adding sections 19a-495-6a to 19a-495-6m as follows:

(NEW) Sec. 19a-495-6a Hospice Inpatient Facilities

(a) Definitions. As used in Sections 19a-495-6a through 19a-495-6m, inclusive, of the Regulations of Connecticut State Agencies.

(1) "Adverse event" means a discrete, auditable and clearly defined occurrence with a negative consequence of care that results in unanticipated injury, illness, or death which may or may not have been preventable;

(2) "Attending practitioner" means a physician, or an advance practice registered nurse, licensed in Connecticut (who may or may not be an employee of the hospice) identified by the terminally ill patient or family as having a significant role in the determination and delivery of the patient's medical care;

(3) "Bereavement" means the extended period of grief, which is usually thirteen months, preceding the death and following the death of a loved one, during which individuals experience, respond and adjust emotionally, physically, socially and spiritually to the loss of a loved one;

(4) "Bereavement counseling" means emotional, psychosocial, and spiritual support and services provided before and after the death of the patient to assist with issues related to grief, loss, and adjustment;

(5) "Clinical experience" means employment in providing patient services in a health care setting;

(6) "Commissioner" means the Commissioner of Public Health, or the commissioner's designee;

(7) "Complementary therapies" means non-traditional therapies that are used in combination with standard medical treatments, including, but not limited to, massage, yoga, art or music therapy;

(8) "Comprehensive assessment" means a thorough evaluation of the patient's physical, psychosocial, emotional and spiritual status and needs related to the terminal illness and related conditions. This includes an evaluation of the caregiver's and family's willingness and capability to care for the patient;

(9) "Contracted services" means services provided by the hospice which are subject to a written agreement with an individual, another agency or another facility;

(10) "Contractor" means any organization, individual or facility that is hired or paid to provide services to hospice patients under a written agreement with the hospice;

(11) "Department" means the Department of Public Health;

(12) "Dietary counseling" means education and interventions provided to the patient and family regarding appropriate nutritional intake as the patient's condition progresses. Dietary counseling is provided by qualified individuals, which may include an advanced practice registered nurse, registered nurse, registered dietician or nutritionist, when identified in the patient centered plan of care;

(13) "Direct service staff" means individuals employed or under written agreement with the hospice inpatient facility whose primary responsibility is delivery of care to patients;

(14) "Family" means an individual or a group of individuals whom the patient identifies as such regardless of blood relation or legal status;

(15) "Full-time" means employed and on duty not less than thirty-five hours per work week on a regular basis;

(16) "Twenty-four hour basis" means services provided twenty-four hours per day, seven days per week;

(17) "Hospice care" means a comprehensive set of services identified and coordinated by an interdisciplinary team to provide for the physical, psychosocial, spiritual, and emotional needs of a terminally ill patient and the patient's family members, which shall be delineated in the individualized patient centered plan of care across all care settings;

(18) "Hospice inpatient facility" means a facility or hospice residence that provides palliative care for hospice patients requiring short-term, general inpatient care for pain and symptom management, end of life care or respite care;

(19) "Initial assessment" means an evaluation of the patient's physical, psychosocial and emotional status at the time of admission related to the terminal illness and related conditions to determine the patient's immediate care and support needs;

(20) "Inpatient respite care" means short-term inpatient care provided to terminally ill patients to provide relief to family members or others caring for the patient;

(21) "Interdisciplinary team" means a group of individuals who work together to meet the physical, medical, psychosocial, emotional and spiritual needs of the hospice patients and families facing terminal illness and bereavement. The team shall include: a physician, registered nurse, social worker, spiritual counselor and other persons as may be deemed appropriate;

(22) "Licensed independent practitioner" means an individual licensed in Connecticut as a physician, or an advanced practice registered nurse;

(23) "Licensee" means the hospice inpatient facility that is licensed in accordance with section 19a-495-6b of the Regulations of Connecticut State Agencies;

(24) "Medical director" means a physician with experience and training in hospice care licensed to practice medicine in Connecticut in accordance with Chapter 370 of the Connecticut General Statutes;

(25) "Nurse" means a person licensed under chapter 378 of the Connecticut General Statutes to practice nursing as an advanced practice registered nurse, registered nurse, or licensed practical nurse;

(26) "Nursing assistant" means the hospice aide, home health aide, or a nurse's aide who is registered and in good standing on the nurse's aide registry maintained by the department in accordance with section 20-102bb of the Connecticut General Statutes;

(27) "Occupational therapy" shall have the same meaning as provided in section 20-74a(1) of the Connecticut General Statutes and shall be performed in accordance with accepted standards of practice and applicable law by an occupational therapist or occupational therapy assistant licensed under Chapter 376a of the Connecticut General Statutes;

(28) "Palliative care" means patient and family-centered care that optimizes quality of life by anticipating, preventing, and treating suffering. Palliative care throughout the continuum of illness involves addressing physical, intellectual, emotional, social, and spiritual needs and the facilitation of patient autonomy, access to information, and choice;

(29) "Patient centered plan of care" means a comprehensive individualized written plan of care established by the interdisciplinary team in collaboration with a licensed independent practitioner, and patient or family that addresses the physical, intellectual, emotional, social, and spiritual needs of the patient;

(30) "Pharmacist" shall have the same meaning as provided in section 20-571(17) of the Connecticut General Statutes;

(31) "Physical Therapy" shall have the same meaning as provided in section 20-66(2) of the Connecticut General Statutes and shall be performed by a physical therapist or physical therapist assistant who is licensed under Chapter 376 of the Connecticut General Statutes;

(32) "Physician" shall have the same meaning as provided in section 20-13a(6) of the Connecticut General Statutes;

(33) "Physician assistant" shall have the same meaning as provided in section 20-12a(5) of the Connecticut General Statutes;

(34) "Quality care" means that the patient receives clinically competent care, that meets current professional standards, is supported and directed in a planned pattern toward mutually defined outcomes, achieves maximum symptom management and comfort consistent with individual potential life style and goals, receives coordinated service through each level of care and is taught self-management and preventive health measures;

(35) "Representative" means a designated member of the patient's family or person legally authorized to act for the patient in the exercise of the patient's rights in accordance with applicable law;

(36) "Restraint" means:

(A) Any manual method, physical or mechanical device, material, or

equipment that immobilizes or reduces the ability of a patient to move the arms, legs, body, or head freely, not including devices, such as orthopedically prescribed devices, surgical dressings or bandages, protective helmets, methods that involve the physical holding of a patient for the purpose of escorting the patient or conducting a routine physical examination or test, methods or devices intended to protect the patient from falling out of bed or allowing the patient to participate in an activity without the risk of physical harm; or

(B) A drug or medication when it is used as a restriction to manage the patient's behavior or restrict the patient's freedom of movement and is not a standard treatment or dosage for the patient's condition;

(37) "Seclusion" means the involuntary confinement of a patient alone in a room or an area from which the patient is physically prevented from leaving;

(38) "Social work services" means services provided in accordance with accepted standards of practice and applicable law by a licensed clinical social worker or licensed master social worker licensed under Chapter 383b of the Connecticut General Statutes;

(39) "Speech and language therapy services" means services provided in accordance with acceptable standards of practice and applicable law by a speech and language pathologist licensed under Chapter 399 of the Connecticut General Statues;

(40) "Spiritual counseling" means the assessment and delivery of services in accordance with the patient and family's beliefs;

(41) "Spiritual counselor" means a person who is ordained clergy (individual ordained for religious service), pastoral counselor or other person who can support the patient's spiritual needs;

(42) "Patient" means a person that is terminally ill and has a medical prognosis with a life expectancy of 6 months or less if the illness runs its usual course; and

(43) "Volunteer" means a person who receives no remuneration for services provided to the hospice.

19a-495-6b Licensure Procedures

(a) No person, group of persons, association, organization, institution or agency, public or private shall establish, conduct or maintain a hospice inpatient facility without a license issued by the Commissioner of Public Health in accordance with this section except as provided in section 19a-491 of the Connecticut General Statutes. Such person or entity shall secure such license and any other required government authorization to provide hospice care services for terminally ill persons on a twenty-four-hour basis in all settings including, but not limited to, a private home, nursing home, residential care home or specialized residence that provides supportive services and shall present to the department satisfactory evidence that such person or entity has retained the services of qualified personnel necessary to provide services in such settings.

(b) Application for initial or renewal licensure.

(1) Application for the initial granting or renewal of a license shall be made by the applicant to the department, in writing, on forms provided by the department.

(2) The application shall be signed by the owner of the hospice inpatient facility or by a person duly authorized to act on behalf of owner of the facility and shall include responses to all the information required on the forms provided by the department. The application shall be signed under oath, the signature

notarized and the application form shall cite the provisions of Connecticut General Statutes sections 53a-157b.

(3) Application for the grant or renewal of a license to operate a hospice inpatient facility shall include the following information, if applicable:
- (A) Names and titles of professional and unlicensed assistive personnel;
- (B) Signed acknowledgement of duties for the administrator, medical director, and director of nurses upon initial application only;
- (C) Patient capacity;
- (D) Total number of employees, by category;
- (E) Services provided;
- (F) Evidence of financial capacity;
- (G) Certificates of malpractice and public liability insurance; and
- (H) Local Fire Marshal's biennial license.
- (I) Affidavits as described in Connecticut General Statutes section 19a-491a(a)(3);
- (J) Reports from criminal history and patient abuse background searches pursuant to Connecticut General Statutes section 19a-491c for the owner of the hospice inpatient facility; any officers, directors, trustees or managing and general partners of the owner; any person having a ten percent or greater ownership interest in the owner; all members of governing authority; the administrator; the medical director; and the director of nurses;
- (K) The licensing or renewal fee; and
- (L) Such additional information as the Department may request.

(4) Any person who makes a material false statement in an application shall be subject to penalties in accordance with section 19a-500 of the Connecticut General Statutes.

(c) Issuance and renewal of license.

(1) The Department may, in its discretion, deny an application for licensure or a renewal application for any of the following reasons:
- (A) The license application or renewal application is not complete;
- (B) The applicant's failure to comply with applicable federal, state and local laws;
- (C) If the Department determines that any of the individuals identified in subsection (b)(3) of this section have been subject to any of the criminal, civil or administrative actions described in section 19a-491a(a)(3) of the General Statutes; or
- (D) A material misstatement of fact is made on an initial or renewal application.

(2) Subject to subsection (c)(1) of this section, the Department may issue a license or renewal of a license to operate the hospice inpatient facility if the Department determines that a hospice inpatient facility is in compliance with the statutes and regulations pertaining to its licensure. The license shall be for a period not to exceed two years.

(3) Each facility providing hospice care not physically connected to a licensed hospice inpatient facility, shall require its own license.

(4) The Department of Public Health shall issue a license to the hospice inpatient facility in the name of the owner of the hospice inpatient facility or legal entity appearing on the application. The license shall not be transferable or assignable.

(5) Each license shall specify:
- (A) The maximum licensed bed capacity; and
- (B) The names of the administrator, medical director and director of nurses; and
- (C) Any provisional waivers of the Regulations of Connecticut State Agencies that have been granted to the hospice inpatient facility.

(6) Notice to public. The licensee shall post the license in a conspicuous place in the lobby or reception room of the facility.

(7) Change in status. Change in ownership, level of care, number of beds or location shall require a new license to be issued. The licensee shall notify the department in writing no later than ninety days prior to any such proposed change.

(8) Change in personnel. The governing authority shall notify the department immediately, and shall confirm in writing not more than five days after such notification to the department, of both the resignation or removal and the subsequent appointment of the hospice inpatient facility's administrator, medical director, or director of nurses.

(9) Failure to grant the department immediate access to the hospice inpatient facility or to the hospice inpatient facility's records shall be grounds for denial or revocation of the hospice inpatient facility's license.

(10) Surrender of license. The administrator shall directly notify each patient or patient representative concerned, the patient's family, the patient's primary physician, and any third party payers concerned at least thirty days prior to the voluntary surrender of the hospice inpatient facility's license or surrender of license upon the department's order of revocation, refusal to renew or suspension of license. In such cases, the license shall be surrendered to the department no later than seven days after the termination of operation.

(d) Waiver.

(1) The commissioner may waive provisions of these regulations if the commissioner determines that such waiver would not endanger the health, safety or welfare of any patient. The commissioner may impose conditions upon granting the waiver that assure the health, safety and welfare of patients, or may revoke the waiver upon a finding that the health, safety, or welfare of any patient has been jeopardized. The commissioner may grant a waiver for a specified period of time subject to renewal in the commissioner's discretion. The licensee may seek renewal of the waiver by submitting the required written documentation specified in subsection (d)(2) of this section.

(2) The licensee requesting a waiver shall do so in writing to the department. Such request shall include:
- (A) The specific regulations for which the waiver is requested;
- (B) Reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the facility upon enforcement of the regulations;
- (C) The specific relief requested;
- (D) Any documentation that supports the request for waiver; and
- (E) Alternative policies and procedures proposed.

(3) In consideration of any request for waiver, the commissioner may consider:
- (A) The level of care provided;
- (B) The maximum patient capacity;
- (C) The impact of a waiver on care provided; and

(D) Alternative policies or procedures proposed.

(4) The Department reserves the right to request additional information before processing the request for waiver.

19a-495-6c Governing Authority

(a) A governing authority shall be established by the licensee for the hospice inpatient facility.

(b) The governing authority shall have the authority and responsibility for the overall management and operation of the hospice inpatient facility and shall adopt bylaws or rules that are periodically reviewed and a notation made of the date of such adoption and review. Such bylaws or rules shall include, but not be limited to:

(1) A mission statement and purpose of the hospice inpatient facility;

(2) Delineation of the powers, duties and voting procedures of the governing authority, its officers and committees;

(3) Qualifications for membership, method of selection and terms of office of members and chairpersons of committees;

(4) A description of the authority delegated to the administrator;

(5) The conflict of interest policy and procedures;

(6) Scope of services offered;

(7) Admission and discharge criteria;

(8) Medical and dental supervision and plans of treatment;

(9) Clinical records;

(10) Personnel qualifications;

(11) Annual review of personnel policies;

(12) Adoption of written policies assuring the protection of patients' rights and patient grievance procedures, a description of which shall be posted conspicuously in the hospice inpatient facility and distributed personally to each patient upon admission; and

(13) Determination of the frequency of meetings of the governing authority.

(c) The bylaws or rules shall be available to all members of the governing authority and the administrator.

(d) The governing authority shall:

(1) Meet as frequently as necessary to fulfill its responsibilities;

(2) Provide a written agenda and minutes for each meeting;

(3) For each meeting, provide minutes that include, but are not limited to, the identity of those members in attendance, reports of the quality assessment and performance improvement program and any patient grievances. Such minutes shall be approved by the governing authority and dated and signed by the secretary; and

(4) Ensure that the agenda and minutes of any of its meetings or any of its committees are available at any time to the Department.

(e) Other specific responsibilities of the governing authority shall include, but not be limited to:

(1) Oversight of the management and operation of the hospice;

(2) Oversight of the financial viability and management of the hospice inpatient facility's fiscal affairs;

(3) Adoption and documented annual review of written bylaws and budget;

(4) Services provided by the hospice inpatient facility and the quality of care rendered to patients and their families;

(5) Provision of a safe physical plant equipped and staffed to maintain the hospice inpatient facility and services in accordance with any applicable local and state regulations and any federal regulations that may apply to federal programs in which the hospice inpatient facility participates;

(6) Appointment of a qualified administrator;

(7) Approval of the administrator's appointment of a medical director;

(8) Approval of an organizational chart that establishes clear lines of responsibility and authority in all matters relating to management and maintenance of the facility and patient care;

(9) Annual review and update of the operation and fiscal plan, including anticipated needs, income and expenses;

(10) Establish and maintain the quality assessment and performance improvement program including, but not limited to, the selection and appointment of a quality assessment and performance improvement advisory committee; review of issues, corrective actions and outcomes; and recommendations for improvement;

(11) Policy and program determination and delegation of authority to implement policies and programs. The establishment of such policies shall include, but not be limited to:

(A) Responsibilities of the administrator and the medical director;

(B) Conflict of interest on the part of the governing authority, professional staff and employees;

(C) Services to be provided;

(D) Criteria for the selection, admission and transfer of terminally ill patients and families;

(E) Patient or family consent and involvement in the development of patient centered plan of care;

(F) Developing a support network when the family is not available and the patient needs and wants that support;

(G) Referrals and coordination with community and other health care facilities or agencies that shall include but not be limited to a mechanism for recording, transmitting and receiving information essential to the continuity of patient care. Such information shall include, but not be limited to:

(i) Patient identification data including name, address, age, gender, name of representative, and health insurance coverage;

(ii) Diagnosis and prognosis, medical status of patient, brief description of current illness, medical and nursing plans of care including information such as drugs and biological products, treatments, dietary needs, baseline laboratory data;

(iii) Functional status;

(iv) Special services such as physical therapy, occupational therapy, speech and language therapy, and any other therapy; and

(v) Psychosocial needs.

(H) Professional management responsibilities for contracted services;

(I) Reports of patient's condition and procedures for the transmission of such reports to patient's physician;

(J) Provisions governing the relationship of the attending physician or the advanced practice registered nurse to the medical director, and the interdisciplinary team; and

(K) Such other matters, as may be relevant to the organization and operation of hospice care.

(12) Ensure that any and all services provided by hospice inpatient facility volunteers and direct service staff are consistent with accepted standards of practice and applicable law;

(13) Maintain an active quality assessment and performance improvement committee and provide any and all services offered in compliance with sections 19a-495-6a to 19a-495-6m, inclusive of the Regulations of Connecticut State Agencies; and

(14) Compliance with any established hospice inpatient facility policy.

(f) Failure of the administrator to implement the bylaws, rules, policies, or programs adopted by the governing authority shall be grounds for disciplinary action against the licensee under section 19a-494 of the Connecticut General Statutes.

19a-495-6d Administration

(a) The governing authority shall appoint a full-time administrator, who possesses:

(1) A master's degree in nursing with an active license to practice nursing in this state and not less than one year of supervisory or administrative experience in a health care facility program which included care of the sick;

(2) A master's degree in public health or administration with a concentration of study in health services administration or social work, and not less than one year of supervisory or administrative experience in a health care facility or program which included care of the sick;

(3) A baccalaureate degree in nursing or a related field with an active license to practice nursing in this state and not less than two years supervisory or administrative experience in a health care facility or program which included care of the sick;

(4) A baccalaureate degree in administration with a concentration of study in health services administration and not less than two years supervisory or administrative experience in a health care facility or program which included care of the sick; or

(5) A license to practice medicine in accordance with chapter 370 of the Connecticut General Statutes and not less than one year supervisory or administrative experience in a health care facility or program which included care of the sick.

(b) The administrator shall:

(1) Implement the bylaws, rules, policies and programs adopted by the governing authority;

(2) Coordinate the activities between the governing authority and the professional staff;

(3) Ensure the hospice inpatient facility's compliance with all local, state and federal laws and regulations that may apply to programs in which the facility participates;

(4) Ensure that there are sufficient qualified staff and services available to meet the needs of patients at all times; and

(5) Obtain a criminal history and patient abuse background search pursuant to section 19a-491c of the Connecticut General Statutes for all employees and volunteers that have direct patient contact or access to patient records within three months from the date of employment for all states the employee has

lived or worked in for the past three years; and shall ensure all contractors obtain the same for staff providing direct patient services.

(c) The administrator, with the approval of the governing authority, shall appoint a medical director who is licensed as a physician, with experience and training in hospice care. The medical director shall be designated by the hospice inpatient facility and be responsible for the coordination and oversight of medical services provided by the hospice inpatient facility.

(1) The medical director shall have the responsibility for:

(A) Coordination and oversight of medical care and services provided;

(B) Ensuring and maintaining quality standards of professional practice;

(C) Implementation of patient care policies;

(D) The achievement and maintenance of quality assurance of professional practices through a mechanism for the assessment of patient and family care outcomes;

(E) Ensuring completion of health care worker screening and immunization requirements;

(F) Certification of patients admitted to the program;

(G) Participation as a member of the interdisciplinary team, in the development, implementation and assessment of patient centered plans of care;

(H) Consulting with licensed independent professionals regarding patient care plans;

(I) Identifying a designee who is a licensed independent practitioner. The designee shall assume the same responsibilities and obligations as the medical director when the medical director is temporarily not available; and

(2) The medical director shall be available for consultation on a twenty-four hour basis and shall be on site at the hospice inpatient facility a sufficient number of hours to meet the responsibilities described in subparagraphs (1) (A) to (1) (I), inclusive of this subsection.

(d) The administrator shall appoint a full-time director of nurses who is licensed as a registered nurse and possesses a baccalaureate degree in nursing with coursework or experience in hospice care. The director of nurses shall have the following qualifications:

(1) A master's degree from a program approved by the Commission on Collegiate Nursing Education or the American Public Health Association with not less than two years' full-time clinical experience or community health program; or

(2) not less than three years of full-time clinical experience in nursing, at least two of which were in a hospice, home health agency or community health program.

(e) The director of nurses shall be responsible for the overall hospice inpatient facility's nursing services, which shall include:

(1) Coordination of professional and non-professional nursing services provided;

(2) Ensuring and maintaining quality standards of professional practice;

(3) Development and implementation of patient care policies;

(4) Participation in the development and implementation of the patient centered plans of care;

(5) Consulting with other interdisciplinary team members regarding patient care; and

(6) Development and implementation of the hospice infection control and hospice safety policies.

(f) Except for a hospice inpatient facility with twelve licensed beds or less, the administrator shall not serve as the director of nurses.

(g) There shall be a written agreement for the provision of services if provided by a contractor and not directly by the hospice inpatient facility. The Commissioner shall have access to the records of the contractor related to performance of the agreement and the provision of services. The agreement shall clearly delineate the responsibilities of the contractor and hospice inpatient facility and shall include but not be limited to the following provisions:

(1) A stipulation that services may be provided only with the express authorization of the hospice inpatient facility;

(2) A stipulation that the hospice inpatient facility is responsible for the admission of patients;

(3) Identification of services to be provided by the contractor that shall be within the scope and limitations set forth in the patient centered plan of care and shall not be altered by the contractor in type, amount, frequency or duration;

(4) Manner in which the contracted services are coordinated, supervised and evaluated by the hospice inpatient facility;

(5) Assurance of compliance with the patient care policies of the licensed hospice inpatient facility;

(6) Establishment of procedures for and frequency of patient and family care assessment;

(7) Furnishing the patient centered plan of care to other health care facilities upon transfer of patient;

(8) Assurance that the qualifications of the personnel and services to be provided meet the requirements of sections 19a-495-6a to 19a-495m, inclusive, of the Regulations of Connecticut State Agencies, including licensure, personnel qualifications, functions, supervision, hospice training and orientation, in-service training, and attendance at case conferences;

(9) Reimbursement mechanism, charges, and terms for the renewal or termination of the agreement;

(10) Such other provisions as may be mutually agreed upon or as may be relevant and deemed necessary;

(11) Assurance that the medical record shall include a record of all services and events, and a copy of the discharge summary and, that, if requested, a copy of the medical record to be provided to the hospice inpatient facility; and

(12) The party responsible for the implementation of the provisions of the agreement.

(h) The licensee shall retain responsibility for contracted services and ensure such services are rendered in accordance with accepted standards of practice and applicable law.

(i) A medical record shall be maintained for every patient who is evaluated or treated at a hospice inpatient facility. The medical records shall be:

(1) Safeguarded against loss, destruction or unauthorized use, and all entries in the patient's medical record shall be written in ink and legible. Electronic medical records shall be consistent with state and federal applicable law, policies and procedures for interoperability, privacy and security.

(2) Started at the time of admission with identification, date, and a nurse's notation of condition on admission. Within twenty-four hours of admission, the

attending practitioner shall add an admission note and orders. The attending practitioner shall record the patient's complete history and physical examination within twenty-four hours of admission, unless the patient's primary provider performed the patient's last history and physical examination within the last thirty days and is following the patient. In such case, the patient's last history and physical examination shall be noted in the medical record and a copy of that history and physical examination shall become part of the medical record.

(3) Prepared accurately and entries completed promptly with sufficient information and progress notes to justify the diagnosis and warrant the treatment and palliation. Physician's orders, nurses' notes and notes from other disciplines including, but not limited to, pastoral, contractor, nurse aide and volunteers, shall be kept current in a professional manner and all entries shall be signed by the person responsible for making the order or note and such person's title.

(4) Kept confidential and secured. Written consent of the patient or the patient's representative shall be required for release of medical information or medical records unless otherwise provided by law.

(5) The records shall be filed and stored in an accessible manner and shall be kept for not less than seven years after discharge of patients, except that original medical records may be destroyed sooner if they are electronically preserved by a accepted mechanism for medical records.

(6) Completion of the patient's medical records shall be accomplished no later than thirty days after discharge or no later than thirty days of death.

19a-495-6e General Requirements

(a) Core services provided directly by the hospice inpatient facility shall, except as provided in subsection (b) of this section, include the following:

(1) Services of a physician or advanced practice registered nurse;

(2) Nursing services provided by a registered nurse, or licensed practical nurse;

(3) Social services;

(4) Counseling services if required;

(5) Pain assessment and management; and

(6) Availability of drugs and biological products on a twenty-four hour basis.

(b) The licensee may use contracted services to supplement the hospice inpatient facility's staff under extraordinary circumstances when it is necessary to meet the needs of the patients. If contractors are used, the licensee shall maintain responsibility for the services and shall assure that the qualifications of staff and services provided meet the requirements of the Regulations of Connecticut State Agencies and relevant Connecticut General Statutes. When a contractor is providing services during an outpatient admission, the licensee and contractor shall have a "Coordination of Outpatient Services Agreement" in place for the provision of services which includes, but is not limited to:

(1) A criminal history and patient abuse background search pursuant to section 19a-491c of the Connecticut General Statutes including, but not limited to, all hospice employees or contracted employees and volunteers who have direct patient contact or access to patient records;

(2) Mechanisms for the collaboration and coordination of care; and

(3) The exchange of information to meet the ongoing needs of the patient and family;

(c) In addition to the core services, the licensee shall ensure that the following services are provided, as needed, by hospice inpatient facility or by a contractor under written agreement with the hospice inpatient facility:
  (1) Home health aide and homemaker services;
  (2) Short-term respite care and general inpatient care;
  (3) Physical therapy, occupational therapy, and speech and language pathology services;
  (4) Medical supplies and appliances;
  (5) Nutrition counseling;
  (6) Complementary therapies; and
  (7) Any other services identified in the patient centered plan of care.

(d) The licensee shall make services available as follows:
  (1) Nursing services, physician services, drugs and biological products continuously available on a twenty-four hour basis;
  (2) All other services available on a twenty-four hour basis to the extent necessary and reasonable to meet the needs of the patient care for the palliation and management of the patient's terminal illness and related conditions in accordance with the patient centered plan of care;
  (3) Assessment capability available on a twenty-four hour basis to respond to acute and urgent patient or family needs; and
  (4) Additional health services or related services may be provided as deemed appropriate to meet the patient's and family's needs, and all services shall be rendered in a manner consistent with accepted standards of practice and applicable law.

(e) The licensee shall ensure patient accessibility to the following:
  (1) A functioning system that enables inpatients or outpatients and their families to make telephone contact with hospice staff on a twenty-four hour basis. Mechanical answering devices shall not be acceptable;
  (2) A system that provides twenty-four hour, pharmacy services for the palliative care and management of the patient; and
  (3) A system that ensures that patients are permitted to receive visitors, including small children and pets, at any hour, provided that a therapeutic environment is maintained.

(f) The licensee shall ensure the continuity of patient and family care through adoption and implementation of written policies, procedures and criteria including the following:
  (1) Coordination of community physicians and nurses with hospice inpatient facility staff prior to and at the time of admission;
  (2) Admission criteria for the initial assessment of the patient or family needs and decision for care;
  (3) Signed informed consent;
  (4) Ongoing assessment of the patient's and family's needs;
  (5) Development and review of the patient centered plan of care by the interdisciplinary team;
  (6) Transfer of patients to inpatient care facilities for inpatient respite care or general inpatient care;
  (7) The provision of appropriate patient and family information at the point of transfer between care settings;
  (8) Community or other resources to ensure continuity of care and to meet patient and family needs;

(9) Management of pain and symptom control through palliative care and utilization of therapeutic services; and

(10) Constraints imposed by limitations of services or family conditions and such other criteria as may be deemed appropriate for each patient and family.

19a-495-6f Hospice Inpatient Facility Services

(a) The licensee shall provide staff in sufficient numbers and services of sufficient duration to meet the physical, psychosocial and spiritual needs of patients and their families. The licensee is responsible for ensuring that staffing for all services reflect its volume of patients, their acuity, and the level of intensity of services needed to ensure that the plan of care outcomes are achieved and negative outcomes are avoided.

(b) The licensee shall provide quality care through the provision of the following services:

(1) Physical, occupational, and speech and language therapy shall be available and when provided, such services shall be rendered by a licensed person in accordance with the patient centered plan of care and in a manner consistent with accepted standards of practice and applicable law.

(2) Attending practitioner services shall be provided by a licensed physician or advanced practice registered nurse to meet the medical needs of patients for the management of the terminal illness and related conditions, through palliative and supportive care. Attending practitioner services shall be provided in accordance with hospice policies in a manner consistent with accepted standards of practice and applicable law. In addition to palliation and management of terminal illness and related conditions, physicians and advanced practice registered nurses that are part of the staff of the hospice inpatient facility or members of the interdisciplinary team, shall meet the medical needs of the patients to the extent that these needs are not met by the attending practitioner.

(3) Bereavement counseling services shall be provided to meet the needs of the family both before and after the death of the patient.

(4) Dietary counseling services for the patient and family shall be available as may be required, while the patient is in hospice care.

(5) Dietary services shall be provided to patients, under the direction of a food service supervisor, who is a qualified food operator as defined in section 19-13-B42 of the Regulations of Connecticut State Agencies. The food services supervisor shall:

(A) Ensure the dietary services operation complies with all applicable state regulations and statutes;

(B) Employ an adequate number of individuals to perform the duties and responsibilities of the food service operation; and

(C) Consult with a registered dietician on a regular basis, and an advanced practice registered nurse, or physician concerning patient's diets, as necessary.

(6) Medical supply services including, but not limited to, appliances, drugs and biological products as may be needed, shall be provided for the palliation and management of the patients' terminal illness.

(7) Nursing assistants shall provide personal care and other related support services under the delegation and supervision of a registered nurse. Duties of nursing assistants shall include, but not be limited to:

(A) Personal care;

(B) Ambulation and exercise;
(C) Assisting a patient with eating;
(D) Reporting changes in a patient's condition and needs;
(E) Completing a patient's medical records as directed; and
(F) Assisting with the patient's self-administration of drugs and biological products by:
(i) Reminding a patient to self-administer the drugs or biological products;
(ii) Verifying that a patient has self-administered their drugs or biological products;
(iii) Opening bottles, bubble packs or other forms of packaging if the patient is not capable of performing this function.

(8) Nursing services shall be provided under the direction of a licensed registered nurse to meet the nursing care needs of the patient and family, as identified in the patient centered plan of care. Nursing services shall be provided in accordance with accepted standards of practice, applicable law and hospice inpatient facility policies. There shall be a registered nurse on the premises on a twenty-four hour basis and there shall be a sufficient number of nursing personnel on a twenty-four hour basis to:
(A) Assess patients' needs;
(B) Assist in the development and implementation of patient centered plans of care;
(C) Provide direct patient care services; and
(D) Coordinate or perform other related activities to maintain the health and safety of the patients.

(9) Pharmacy services shall be provided under the direction of a licensed pharmacist who is an employee of or has a written agreement with the hospice inpatient facility. Duties of the pharmacist shall include, but not be limited to the following:
(A) Identification of potential adverse drug reactions, and recommended appropriate corrective action;
(B) Compounding, packaging, labeling, dispensing, and distributing all drugs to be administered to patients;
(C) Monitoring patient drug therapy for potential drug interactions and incompatibilities at least monthly with documentation of same;
(D) Inspecting all areas within the facility where drugs (including emergency supplies) are stored at least monthly to assure that all drugs are properly labeled, stored and controlled; and
(E) Serving as a consultant to the interdisciplinary team for pain control and symptom management.

(10) Spiritual counseling services shall be provided in accordance with the wishes of the patient as noted in the patient centered plan of care. Services may include, but not be limited to:
(A) Communication and support from a spiritual counselor;
(B) Consultation and education for the patient, family and interdisciplinary team members.

(11) Social work services shall be provided as identified in the patient centered plan of care and in accordance with accepted standards of practice, applicable law and hospice inpatient facility policies. The social worker's functions shall include, but not be limited to:

(A) Comprehensive evaluation of the psychosocial status of the patient and family as it relates to the patient's illness and environment;
(B) Counseling of the patient, family and primary caregivers;
(C) Participation in development of the patient centered plan of care; and
(D) Participation in ongoing case management with the hospice inter-disciplinary team.

(12) Volunteer Services shall be provided under the supervision of designated hospice inpatient facility employees.
(A) Volunteers may provide administrative services or non-direct patient care services under the supervision of designated hospice employees;
(B) Direct patient care services may be provided by licensed or registered volunteers who meet the requirements for the provision of such services, under the supervision of appropriate, licensed hospice employees;
(C) The licensee shall provide and document a volunteer orientation and training program for each volunteer;
(D) Volunteer services involving any direct patient care services shall be provided in accordance with the patient centered plan of care.

19a-495-6g In-service Training and Education

(a) In-service educational programs shall be conducted. Such programs shall include but not be limited to:
(1) An orientation program for new personnel, volunteers and contracted staff who provide care to hospice inpatient facility patients. The orientation program shall be provided before the start of employment, volunteering, or provision of contract services at the hospice inpatient facility. The orientation program shall address:
(A) The purpose, goals, mission and philosophy of hospice care; and
(B) Each individual's specific duties.
(2) Not less than once a year, a training program for employees, volunteers and contracted staff who provide care to hospice patients for the development and improvement of hospice-related skills that are identified by the quality assessment and performance improvement program;
(3) Annual training for all employees of the hospice facility, volunteers and contracted staff in:
(A) Prevention and control of infection;
(B) Patient rights and confidentiality;
(C) Fire prevention and safety; and
(D) Food services and sanitation.

(b) The administrator shall assess the skills and competency of all individuals providing patient care and, as necessary, provide in-service training.

(c) The administrator shall maintain documentation and an attendance list of all in-service programs and education for a period of three years after completion.

19a-495-6h Patient Rights and Hospice Responsibilities

(a) The licensee shall have a written bill of rights and responsibilities governing services, which shall be provided and explained to each patient, family or representative at the time of admission. The medical record of each patient shall contain documentation of compliance with this provision.
(1) The patient's rights and responsibilities shall include, but are not limited to:

(A) Be afforded considerate and respectful care;
(B) Receive effective pain management and symptom control on a twenty-four hour basis for the palliation and management of the terminal illness and related conditions;
(C) Be involved in the development of the patient centered plan of care;
(D) Be fully informed of one's condition;
(E) Refuse care or treatment;
(F) Choose an attending physician;
(G) Have a confidential medical record;
(H) Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property;
(I) Receive information about the services covered under the hospice benefits, which shall include but not be limited to a description of available services, unit charges and billing mechanisms;
(J) Receive information about the scope of services that the hospice shall provide and specific limitations on those services including, but not limited to, the hospice inpatient facility's policy on uncompensated care and criteria for admission to and discharge from service;
(K) Receive an explanation of the grievance procedure and the right to file a grievance without discrimination or reprisal regarding treatment or care to be provided or regarding the lack of respect for property by anyone providing hospice care;
(L) Receive information concerning the procedure for registering complaints with the commissioner and information regarding the availability of the Medicare toll-free hotline, including telephone number, hours of operation for receiving complaints; and
(M) Be free from unnecessary restraint and seclusion.

(b) The licensee shall ensure compliance with subsection (a) of this section and shall:
(1) Immediately investigate all complaints made by a patient, family, representative, hospice inpatient facility employee, volunteer or contractor regarding the quality or appropriateness of treatment or care provided to a patient;
(2) Ensure that any employee or volunteer of the hospice inpatient facility or any contractor having reasonable cause to suspect or believe that a patient has been abused, neglected or mistreated reports the abuse, neglect or mistreatment to the administrator and Department. An oral report to the administrator shall be made immediately. A written report to the administrator and Department shall be made as soon as practicable but no later than twenty-four hours after said employee, volunteer or contractor has reasonable cause to suspect or believe that a patient has been abused, neglected or mistreated;
(3) Ensure that all allegations of patient abuse, neglect or mistreatment are thoroughly investigated. Such investigation shall be initiated within 24 hours of the oral report and concluded within 5 days of receipt of the written report;
(4) Ensure that any further potential abuse, neglect or mistreatment has been prevented while the investigation is in progress; and
(5) Report the results of all investigations to the Department not more than 5 days after the investigation has concluded.

(c) Unanticipated events resulting in hospitalization or death of any patient shall be immediately investigated and reported to the administrator and Department within twenty-four hours. All patient deaths occurring within the hospice inpatient facility that are suspicious or unnatural, including, but not limited to, trauma, a drug overdose, poisoning, or an infectious disease with epidemic potential shall immediately be reported to the hospice administrator and the Department.

19a-495-6i Quality Assessment and Performance Improvement

(a) The licensee shall implement the quality assessment and performance improvement program established by the governing authority that includes all patient care disciplines and services provided, including those services provided by a contractor, throughout the hospice inpatient facility. The governing authority shall ensure that the program reflects the complexity of its organization and services, involves leadership working with input from facility staff, patients and families, involves all hospice services including those furnished under contract or arrangement, focuses on performance indicators to monitor a wide range of care processes and outcomes related to palliative care, and initiates actions to demonstrate improvement in hospice performance and promote sustained improvement.

(b) Such plan and program shall be ongoing and shall include:
- (1) Oversight responsibility and program objectives;
- (2) The use of quality indicator data to assess and monitor patient care and services;
- (3) Evidenced based practices and policies for:
  - (A) Pain and symptom management;
  - (B) The prevention and treatment of pressure sores;
  - (C) The prevention of abuse, neglect and mistreatment;
  - (D) The prevention of accidents and injuries; and
  - (E) The prevention, surveillance and control of health care associated infections and communicable diseases.
- (4) A method and mechanism for identifying, and as required, reporting:
  - (A) Infectious and communicable disease occurrences among patients and personnel;
  - (B) Health care associated infections and a plan for the implementation of actions that are expected to result in improvement and disease prevention;
  - (C) Adverse events; and
  - (D) Potential sources of injuries and medical errors and a plan for the implementation of actions that are expected to result in improvement and prevention of such occurrences.
- (5) Review and investigation of all adverse events;
- (6) Other criteria and data necessary to monitor the quality of patient care; and
- (7) Evidence based practices to identify, evaluate, and correct problems.

(c) The hospice inpatient facility administrator shall designate a licensed employee to coordinate and manage the quality assessment and performance improvement program. The licensed employee shall ensure that:
- (1) Program activities focus on high risk, high volume, or problem-prone areas;
- (2) The program maintains records of appropriate corrective action to address problems identified through the quality assessment and performance improvement program; and

(3) The outcome of the corrective action is documented and submitted to the governing authority for its review.

(d) The members of the quality assessment and performance improvement committee members as described in section 19a-495-6c(e)(10) of the Regulations of Connecticut State Agencies shall be employees of the hospice inpatient facility and shall include at least one licensed independent practitioner, one registered nurse, and spiritual counselor.

(e) The functions of the quality assessment and performance improvement committee shall be to:
- (1) Monitor the effectiveness and safety of services and quality of care;
- (2) Identify opportunities for improvement;
- (3) Recommend the frequency and detail of data collection to the governing authority;
- (4) Develop, implement and evaluate performance improvement projects based on the hospice inpatient facility's population and needs that reflect the scope, complexity and past performance of the hospice inpatient facility's services and operations;
- (5) Ensure there is a rationale as well as a goal and measurable objectives for each project that is implemented;
- (6) Ensure progress is documented for each project;
- (7) At least annually review and recommend to the governing authority revisions to the hospice inpatient facility's policies relating to:
  - (A) Quality assessment and improvement activities;
  - (B) Standards of care;
  - (C) Professional issues especially as they relate to the delivery of services and findings of the quality assessment and improvement program.

(f) The quality assessment and performance improvement committee shall meet at least twice per year and shall maintain records of all quality improvement activities.

(g) Written minutes shall document dates of meetings, attendance, agenda and recommendations. The minutes shall be presented, reviewed, and accepted at the next regular meeting of the governing authority of the hospice inpatient facility following the quality assessment and performance improvement committee meeting. These minutes shall be available upon request to the commissioner.

19a-495-6j Assessment and Patient Centered Plan of Care

(a) At the time of admission, an initial assessment shall be completed to identify and meet the immediate needs of the patient. Within forty-eight hours of a patient's admission, a licensed registered nurse shall complete the assessment to evaluate the patient's immediate physical, psychosocial, emotional, and spiritual status.

(b) Not later than five days after a patient's admission to the hospice inpatient facility, the interdisciplinary team shall complete a comprehensive assessment for the patient shall include but not limited to the following:
- (1) History of pain, symptoms, and treatment;
- (2) Characteristics of pain and symptoms;
- (3) Physical examination;
- (4) Current medical conditions and drugs and biological products;
- (5) Patient or family's goal for pain and symptom management;
- (6) Condition causing admission;
- (7) Relevant history as well as complications and risk factors that affect care planning;

(8) Functional status;
(9) Imminence of death;
(10) Severity of symptoms;
(11) Drug profile;
(12) Bereavement;
(13) The need for referrals or further evaluation by appropriate health professionals; and
(14) Data elements that allow for the measurement of patient outcomes and are related to aspects of care.

(c) The comprehensive assessment shall be updated as frequently as the condition of the patient requires, but not less than once every fourteen calendar days.

(d) Upon completion or update of the comprehensive assessment, a written patient centered plan of care shall be established or revised for the patient.

(e) Such patient centered plan of care shall be developed to include only those services that are acceptable to the patient and family.

(f) The patient and family shall be involved whenever possible in the implementation and continuous assessment of the patient centered plan of care.

(g) The interdisciplinary team shall ensure that the patient and family receive education and training provided by the licensee regarding the responsibilities of the patient and family for the care and services identified in the patient centered plan of care.

(h) The patient centered plan of care shall include, but not be limited to:
(1) Pertinent diagnosis and prognosis;
(2) Interventions to facilitate the management of pain and other symptoms;
(3) Measurable targeted outcomes anticipated from implementing and coordinating the patient centered plan of care;
(4) A detailed statement of the patient and family needs addressing the:
(A) Physical, psychological, social, and spiritual needs;
(B) The scope of services required;
(C) The frequency of services;
(D) The need for respite or general inpatient care;
(E) Nutritional needs;
(F) Drugs and biological products;
(G) Management of pain and control of other symptoms; and
(H) Management of grief.
(5) Drugs and treatments necessary to meet the needs of the patient;
(6) Medical supplies and appliances necessary to meet the needs of the patient;
(7) The interdisciplinary team's documentation of the patient's and family's understanding, involvement, and agreement with the patient centered plan of care; and
(8) Such other relevant modalities of care and services as may be appropriate to meet individual patient and family care needs.

(i) The patient centered plan of care shall be reviewed and updated by the interdisciplinary team as needed, but not less than once every fourteen calendar days. This review and update shall be documented in the medical record.

(j) A revised patient centered plan of care shall include information from the patient's updated comprehensive assessment and the patient's progress toward outcomes specified in the patient centered plan of care.

19a-495-6k Drugs and Biological Products

(a) The interdisciplinary team shall confer with a licensed pharmacist or independent practitioner with education and training in drug management, who is an employee of or has a written agreement with the hospice inpatient facility, to ensure that drugs and biological products meet the patient's needs on a twenty-four hour basis.

(b) Only a licensed independent practitioner shall order drugs and biological products for the patient, in accordance with the patient centered plan of care.

(1) The written or electronic order shall only be given to a registered nurse, advanced practice registered nurse, physician assistant, pharmacist, or physician; and

(2) If the drug order is verbal, the registered nurse, advanced practice registered nurse, pharmacist, or physician receiving the order shall record, read back and sign it immediately, and have the prescribing person sign the order in accordance with state and federal regulations and statutes.

(c) The licensee shall ensure that:

(1) Drugs and biological products are obtained from community or institutional pharmacies or establish its own institutional pharmacy licensed by the Department of Consumer Protection in accordance with section 20-594 of the Connecticut General Statutes;

(2) A written policy in place that promotes dispensing accuracy;

(3) Current and accurate records of the receipt and disposition of all controlled drugs are maintained; and

(4) Drugs and biological products are only administered to patients by a licensed nurse, physician's assistant, or licensed independent practitioner consistent with accepted standards of practice and applicable law.

(d) Drugs and biological products shall be labeled in accordance with currently accepted professional practice and shall include appropriate usage and cautionary instructions, as well as an expiration date.

(e) Drugs and biological products shall be stored all in a secure area. Controlled drugs listed in Schedules II, III, IV, and V of the Comprehensive Drug Abuse Prevention and Control Act of 1976 shall be stored in locked compartments within such secure storage areas. Only personnel authorized to administer controlled drugs shall have access to the locked areas.

(f) Controlled drugs shall be disposed of in compliance with the hospice policy and in accordance with state and federal requirements.

(g) Discrepancies in the acquisition, storage, dispensing, administration, disposal, or return of controlled drugs shall be investigated immediately by the pharmacist and administrator, and where required, reported to the appropriate state authority. A written account of the investigation shall be made available to state and federal officials as required by law.

19a-495-6l Medical Supplies and Durable Equipment

(a) The licensee shall:

(1) Comply with manufacturer recommendations for performing routine and preventive maintenance on durable medical equipment; and

(2) Develop routine repair and maintenance policies when a manufacturer recommendation does not exist for such durable medical equipment.

(b) All durable medical equipment shall be safe and work as intended for use in the patient's environment.

(c) The licensee shall ensure that the patient, family, and any other caregiver, as appropriate, receive instruction in the safe use of durable medical equipment and medical supplies. The licensee may contract with an outside entity to be responsible for ensuring that durable equipment is properly maintained and repaired.

19a-495-6m Hospice inpatient Facility Physical Plant

(a) All buildings shall be of sound construction. Equipment and furnishings shall be maintained in good condition, properly functioning and repaired or replaced when necessary. Requirements shall include:

(1) New construction and renovation of hospice inpatient facility buildings and systems shall meet the requirements of the Connecticut State Fire Code, National Fire Protection Association Standards, Health Care Facilities, No. 99; Connecticut State Building Code, applicable local codes and ordinances and the 2010 edition of the Facility Guidelines Institute (FGI)/ American Institute of Architects (AIA) Guidelines for Design and Construction of Health Care Facilities.

(2) An operations and preventative maintenance program shall be established and implemented on an ongoing basis to maintain the building, systems, equipment and grounds in a clean, sanitary, safe and operational condition.

(3) A program shall be established and maintained to provide for the safety and well-being of the building occupants and shall provide for the testing, servicing and maintenance of all life safety, emergency and bio-medical equipment in accordance with applicable state laws and regulations and manufacturer recommendations.

(4) Records of all inspections, testing, maintenance and repairs shall be maintained for Department review.

(b) Plans and specifications for new construction and rehabilitation, alteration, addition, or modification of an existing structure shall be approved by the Department on the basis of compliance with the Regulations of Connecticut State Agencies after the approval of such plans and specifications by local building inspectors and fire marshals, and prior to the start of construction.

(c) All floors within the hospice inpatient facility, other than the main entrance floor shall be accessible by elevator. The cars of elevators shall have inside dimensions that shall accommodate a patient bed and attendants.

(d) All hospice inpatient facilities licensed for more than one hundred and twenty beds shall be connected to a public water supply and sanitary sewer systems.

(e) Water temperatures shall meet the following requirements to ensure patient safety:

(1) In patient areas, hot water temperatures shall not be less than one hundred degrees Fahrenheit and shall not exceed one hundred ten degrees Fahrenheit;

(2) Thermostatic or pressure balanced mixing valves are required at each site or fixture used for immersion or showering of patients; and

(3) Thermometers or skin sensory methods shall be used to verify the appropriateness of the water temperature prior to each use.

(f) An emergency source of electricity shall be provided to protect the health and safety of patients in the event the normal electrical supply is interrupted. The source of the emergency electrical service shall be an emergency generator, which shall be located on the premises and shall be reserved exclusively for supplying the emergency electrical system.

(1) When fuel to the building is not piped from a utility distribution system, fuel shall be stored on site sufficient to provide seventy-two hours of continuous service.

(2) The emergency source shall have the capacity for:

(A) Delivering eighty percent of normal power;

(B) Lighting all means of egress;

(C) Equipment to maintain detection, alarm, and extinguishing systems;

(D) Life support systems; and

(E) Routine patient care.

(g) Patient areas shall be designed and equipped for the comfort and privacy of each patient and family that includes:

(1) Physical space for private patient and family visiting;

(2) Accommodations for family members, including children, if they wish to remain with the patient overnight;

(3) family privacy after a patient's death; and

(4) A home like environment to the extent possible.

(h) Patient rooms shall have a maximum capacity of one patient per room and be located within one hundred and thirty feet of a nursing station.

(i) Patient bathing facilities shall include:

(1) One shower stall or bathtub for every fifteen beds not individually served;

(2) A toilet and sink directly accessible to the bathing area; and

(3) Bathing and shower rooms shall be of sufficient size to accommodate one patient and one attendant and shall not have curbs.

(j) Service area requirements shall include but not be limited to:

(1) Hand washing facilities conveniently located next to each nurses' station and drug distribution station;

(2) A janitor's closet that contains a floor receptacle or service sink, and locked storage space for housekeeping equipment and supplies;

(3) A family and patient common area with not less than two hundred twenty-five square feet for every thirty beds;

(4) A common dining area with fifteen square feet per patient to accommodate the total patient capacity of the facility that may be combined with the recreation area;

(5) A single recreation area of thirty-five square feet per patient and provisions for storage;

(6) A comfortable space for spiritual purposes, which shall be appropriately equipped and furnished;

(7) For those patients who do not have a private room, a separate room shall be made available for the viewing of a deceased patient's body until released to the responsible agent;

(8) A dietary service area of adequate size that includes, but is not limited to:

(A) A breakdown and receiving area, storage space for a three day food supply including cold storage;

(B) Food preparation facilities with a lavatory;

(C) Meal service facilities;

(D) Dishwashing space in a room or alcove separate from food preparation and serving areas with commercial-type dishwashing equipment and space for receiving, scraping, sorting, and stacking soiled tableware;

(E) Pot washing facilities;

(F) Storage areas for supplies and equipment;

(G) Waste storage facilities in a separate room easily accessible to the outside for direct pickup or disposal;
(H) An icemaker-dispenser unit;
(I) A janitor's closet that contains a floor receptacle or service sink; and
(J) Locked storage space for housekeeping equipment and supplies.

(k) An entrance at grade level, sheltered from the weather, and able to accommodate wheelchairs.

(l) Access to the hospice inpatient facility shall be physically and operationally distinct from other patient care facilities that share the facility space. Visitors shall be prohibited from passing through the hospice inpatient facility space to access another area of the building.

(m) There shall be a laundry service. The licensee may contract for these services. If laundry services are provided on site, they shall comply with the following requirements:
(1) A laundry processing room with commercial-type equipment;
(2) A soiled linen receiving, holding and sorting room with hand washing facilities;
(3) Storage for laundry supplies;
(4) Deep sink for soaking clothes;
(5) Clean linen storage, holding room and ironing area;
(6) Janitor's closet containing a floor receptacle or service sink, and locked storage space for housekeeping equipment and supplies;
(7) Off-site processing requires a soiled linen holding room with hand washing facilities, and a clean linen receiving, holding, inspection and storage room; and
(8) Each hospice inpatient facility shall have a domestic type washer and dryer located in a separate room for patients' personal use.

(n) Provisions shall be made by the licensee to ensure the following are maintained at all times:
(1) Adequate and comfortable lighting levels in all areas;
(2) Limitation of sounds at comfortable levels;
(3) Comfortable temperature levels for the patients in all parts of patient occupied areas with a centralized heating system to maintain not less than seventy degrees Fahrenheit during the coldest periods;
(4) Adequate ventilation through windows or by mechanical means;
(5) Corridors equipped with firmly secured handrails on each side; and
(6) Heat relief to patients when the outdoor temperature exceeds eighty degrees Fahrenheit and air conditioning is not available.

Section 3. 19-13-D4b of the Regulations of the Connecticut State Agencies is repealed.

(Statement of Purpose page)

Statement of Purpose

Statement of Purpose Includes: (A) The purpose of these regulations is to repeal section 19-13-D4b, maintain current language governing Short-term Hospital, special, hospice and create new regulations regarding Hospice Inpatient Facilities pursuant to section 19a-495 of the Connecticut General Statutes; (B) These regulations will create a new licensure category for Hospice Inpatient Facilities while keeping the existing short-term hospital, special, hospice regulation intact. Sections 19a-495-6a through 19a-495-6m is consistent with federal guidelines and current healthcare delivery standards. Entities previously licensed under section 19-13-D4b will continue to comply with the requirements for short-term hospital, special, hospice regulations previously located in section 19-13-D4b now section 19a-495-5b of the Regulations of Connecticut State Agencies; (C) These regulations will repeal section 19-13-d4b and create sections 19a-495-5a through 19a-495-5b and 19a-495-6a through 19a-495-6n. The Department plans to use sections 19a-495-1 through 19a-495-4 for future regulations.