

RULES ~~AND REGULATIONS~~
FOR HOSPICE IN ARKANSAS



ARKANSAS DEPARTMENT OF HEALTH

Health Facility Services

2010

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SECTION 1: PREFACE

These rules ~~and regulations~~ have been prepared for the purpose of establishing criteria for minimum standards for the licensure operation and maintenance of hospices in Arkansas that is consistent with current trends in patient care practices. By necessity they are of a regulatory nature but are considered to be practical minimal design and operational standards for these facilities. These standards are not static and are subject to periodic revisions in the future as new knowledge and changes in patient care trends become apparent. However, it is expected that facilities will exceed these minimum requirements and that they will not be dependent upon future revisions in these standards as a necessary prerequisite for improved services. Hospices have a strong moral responsibility for providing optimum patient care and treatment for the terminally ill and their families.

SECTION 2: AUTHORITY

The following Rules ~~and Regulations~~ for Hospices in Arkansas are duly adopted and promulgated by the Arkansas State Board of Health pursuant to the authority expressly conferred by the laws of the State of Arkansas in Ark. Code Ann. § 20-7-117, § 20-7-123, and § 20-38-101 et seq..

SECTION 3: PURPOSE

To establish rules, ~~regulations and~~ minimum standards for hospice programs operating in the State of Arkansas ~~in accordance with Ark. Code Ann. § 20-7-117~~. These rules will ensure high quality professional care for terminally ill patients and their families by providing for the safe, humane and appropriate palliative care of all admitted to hospice program regardless of setting and shall apply to both new and existing agencies.

SECTION 4: DEFINITIONS

The word **shall** as used in these ~~regulations~~ rules means mandatory.

- A. Administrator means the person responsible for the management of a hospice.
- B. Attending physician means a doctor of medicine or osteopathy who is licensed in the state of Arkansas; and is identified by the patient, at the time he/she elects to receive hospice care, as having the most significant role in the determination and delivery of the patient's medical care.
- C. Autonomous means a separate and distinct entity which functions under its own administrations and bylaws either within or independently of a parent organization.
- D. Bereavement counseling means counseling services provided to the patient's family after the patient's death.
- E. Clergy or Pastoral Counselor means an individual with training in spiritual counseling.
- F. Department means the Arkansas Department of Health ~~and Human Services and Human Services~~.
- G. Election Statement means the initial election for hospice care signed by the patient or patient's representative.
- H. Employee means an individual paid either through a salary or on an hourly or per visit basis and a W2 is issued on his/her behalf. An "employee" also refers to a volunteer under the jurisdiction of the hospice.
- I. Health Facility Services is the facility licensing division of the Department.
- J. Hospice Agency means any agency, person, partnership, association, corporation, or other organization whether public or private, proprietary, or non-profit, that provides hospice service.

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- K. Hospice or hospice care means an autonomous, centrally administered, medically directed, coordinated program providing a continuum of home, outpatient, and home-like inpatient care for the terminally ill patient and family, employing an interdisciplinary team to assist in providing palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social and economic stresses which are experienced during the final stages of illness and during dying and bereavement, with such care being available 24 hours a day, 7 days a week and provided on the basis of need regardless of ability to pay
- L. Informed Consent specifies the type of care and services agreed upon by the hospice patient or the patient's representative.
- M. In-patient Direct Care Hospice means a licensed hospice facility that provides direct in-patient care to the terminally ill.
- N. Functional Program describes those services to be provided by the Hospice for the operation of the facility.
- O. Registered Nurse (RN) means a person licensed in the State of Arkansas as a registered nurse.
- P. Representative means a person who is, because of the patient's mental or physical incapacity, authorized in accordance with State law to execute or revoke an election for hospice care or terminate medical care on behalf of the terminally ill patient.
- Q. Satellite Office or Alternate Delivery Site - An approved location or site from which a hospice provides services within a portion of the total geographic area served by the parent hospice agency.
- R. Service Area - The geographic land area for which the agency shall be licensed consistent with the agency's Permit of Approval (POA) or the service area of record prior to the requirement for a POA.
- S. Social Worker means a person who has at least a Bachelor's Degree from a school accredited or approved by the Council on Social Work Education and is licensed by the State of Arkansas as a Social Worker.
- T. Terminally ill means that the patient is in the last phases of an incurable illness or condition and has a limited prognosis.

SECTION 5: REQUIREMENTS AND CODES

All agencies providing hospice services in the home shall comply with Sections 1 thru 21. In-Patient Direct Care Hospices shall comply with Sections 1 thru 34.

A. Licensure

1. No public or private agency or person shall establish, conduct, or maintain a hospice or hold itself out to the public as a hospice without first obtaining licensure from the department.
2. Licensure to operate a hospice issued by the Department shall be based upon the results of an operational and physical plant survey conducted by the Department to determine compliance with the Rules ~~and Regulations of~~ for Hospice. Licensure for the operation of a hospice program shall, unless sooner revoked, be for a period of one year.

B. Revocation

1. The department may deny, suspend or revoke a license on any of the following grounds:
 - a. Violation of any of the ~~rRules for Hospice and regulations promulgated as developed under the authority of Ark. Code Ann. § 20-7-117.~~
 - b. Permitting, aiding or abetting the commission of any unlawful act in connection with the operation of a hospice.
2. Revocation shall be effective for a minimum of 90 days before the Department accepts reapplication.
3. Right of Appeal shall be through the Arkansas Board of Health.

C. Application

1. An applicant shall file applications under oath with the Department upon forms prescribed by the Department. The application shall be signed by the owner; if a partnership or corporation, by two of its officers; in the case of a governmental unit by the head of the governmental unit having jurisdiction.
2. The application shall set forth the full name and address of the hospice for which state licensure is sought and such additional information as the department may require.

3. An agency making initial application or requesting a change in service area shall submit a Permit of Approval (POA) from the appropriate agency.

D. Change of Ownership

1. The hospice shall notify Health Facility Services in writing at least 30 days prior to the effective date of change of ownership.
2. The following information shall be submitted:
 - a) License application;
 - b) Request for Medicare Certification (where applicable);
 - c) Legal documents, ownership agreements, the license previously issued to the hospice, and other information to support re-license requirements; and
 - d) Licensure fee.

E. Name/Address Change

1. The hospice shall notify Health Facility Services in writing of any name and/or address change.
2. The following information shall be submitted:
 - a) The new address.
 - b) The previously issued license shall be returned to Health Facility Services.
 - c) Appropriate fee.

F. Management Contract

The licensed hospice shall notify Health Facility Services in writing at least 30 days prior to entering into a contract for overall management of the hospice. A copy of the contract shall be submitted to Health Facility Services.

G. Inspections

Any authorized representative of the department shall have the right to enter a hospice at any time in order to make whatever inspection is deemed necessary in accordance with the minimum standards and ~~regulations~~ rules prescribed herein.

SECTION 6: GOVERNING BODY

- A. The hospice shall have a Governing Body that assumes full legal responsibility for determining, implementing and monitoring policies governing the hospice's total operation.
- B. The Governing Body shall designate an individual who is responsible for the day-to-day management of the hospice program.
- C. The Governing Body shall designate a medical director who assumes overall responsibility for the medical component of patient care.
- D. The Governing Body's records shall reflect direct involvement in hospice policy development and oversight to include but not limited to:
 - 1. Responsibilities of the administrator and medical director;
 - 2. Management of contracted services;
 - 3. Patient admission criteria;
 - 4. Patient and family involvement in patient care planning;
 - 5. An ongoing, comprehensive self-assessment of the quality of care provided to patients.
- E. There shall be a schedule of not less than quarterly meetings during each calendar year and minutes shall be maintained of the meetings.
- F. The Governing Body shall ensure:
 - 1. Nursing services, physician services, drugs and biologicals are routinely available on a 24-hour basis;

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2. All other services are available on a 24-hour basis to the extent necessary to meet the needs of patients for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions;
and
3. All services provided are consistent with accepted standards of practice.

SECTION 7: PATIENT RIGHTS AND RESPONSIBILITIES

- A. A hospice shall inform and document that each patient, or when appropriate the patient's representative, has been informed of the following before or during the initial evaluation:
1. The right to appropriate and professional quality services regardless of race, creed, color, religion, sex, national origin, sexual preference, disability or age, and to be free from physical abuse, mental abuse and/or neglect. The patient and property shall be treated with dignity and respect by all that provide services;
 2. The right to receive an explanation of the informed consent and election statement that is signed by the patient or patient's representative for the provision of hospice care;
 3. The right to participate in the decision-making process regarding where care is to be delivered and the options available;
 4. The right to receive a timely response from the hospice agency regarding any request for services;
 5. The right to privacy and confidentiality;
 6. The right to be informed of the name of the hospice agency, services offered by the agency, services being provided to the patient, and how to contact that agency during all hours;
 7. The right to be informed of the process of submitting and addressing complaints to the hospice agency and be informed of the address and phone number of the State Licensing Agency;
 8. The right to be informed that a hospice may not discontinue or diminish care because of the lack of a payor source; and
 9. The right to be informed orally and in writing, prior to service, of expected payment sources, i.e., Medicare, Medicaid, and various other payers.
 10. Services the hospice does not cover.
- B. The agency shall provide each patient and patient's representative with a list affirming the patient's and patient's representative's responsibility to:

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1. Assist in developing and maintaining a safe environment, when possible;
2. Treat all agency staff with respect;
3. Participate in the development and update of the plan of care; and
4. Adhere to the plan of care as developed by the agency and assist in the care as necessary.

SECTION 8: ADMINISTRATION

A. Administration shall provide and document the following:

1. Job descriptions for all employees and volunteers;
 2. Policies and procedures for each available service;
 3. In-services pertinent to hospice care shall be ongoing for employees, volunteers, and contracted staff;
 4. Orientation for all employees, volunteers and contracted staff; and
 5. Annual review of policies and procedures.
6. Criminal history checks for employees and volunteers as required by Ark. Code Ann. §20-38-101 et seq.

B. Services by Arrangement

A hospice may arrange for another individual or entity to furnish services to the patients. If services are provided under arrangement (i.e. under contract), the following standards shall be met:

1. Continuity of Care

The hospice program shall ensure the continuity of patient/family care in home, outpatient, and in-patient settings.

2. Written Agreement

The hospice shall have a written agreement for the provision of contracted services. The contract shall include at least the following:

- a) Identification of services to be provided; and
- b) Qualifications of personnel providing the services.

C. Short Term Inpatient care

The hospice shall have a written agreement approved with an area hospital,

hospice in-patient facility, or qualified skilled nursing facility which states that the hospice may continue to follow any hospice patient admitted to that facility.

D. Continuation of Care

A hospice may not discontinue or diminish care because of the lack of a payor source.

E. Licensure

The hospice and all hospice employees shall be licensed in accordance with applicable Federal, State and local laws.

F. Core Services

A hospice shall ensure all core services (i.e., Nursing, Medical Social Services, and Counseling) described in the following section are routinely provided directly by hospice employees. A hospice may use contracted staff if necessary to supplement hospice employees in order to meet the needs of patients during periods of peak patient loads or under extraordinary circumstances. If contracting is used, the hospice shall maintain professional, financial, and administrative responsibility for the services and shall assure the qualifications of staff and services provided meet the requirements specified for Nursing, Medical Social Services, Physician Services, and Counseling.

NOTE: Physician Services may be provided by an individual contract. The contract must specify the physician will assume all responsibilities as outlined in Section 11.

G. Post Mortem Procedures

The Hospice Agency shall have a procedure addressing post mortem procedures.

H. Pet Therapy

Pet Therapy may be provided by the hospice in the patient's home. Birds, cats, dogs, and other animals may be permitted in the patient's home. Therapy animals shall have appropriate vaccinations and licenses. A veterinary record shall be kept on all therapy animals to verify vaccinations and be made readily available for review and shall not negatively affect the well being of the patient.

I. Employee Health

It shall be the responsibility of Administration, with advice and guidance from the Medical Staff and the Infection Control Committee, to establish and enforce policies concerning pre-employment physicals and employee health. The policies shall include but are not limited to:

1. Requirements for an up-to-date health file for each employee;
2. ~~Annual testing of each employee having direct patient contact for tuberculosis. Each employee having direct patient contact, regardless of whether the employee is a reactor, non-reactor, or converter, shall be tested or evaluated in accordance with the applicable section of the Tuberculosis Manual of the Arkansas Department of Health and Human Services; There shall be measures for prevention of communicable disease outbreaks, especially mycobacterium tuberculosis (TB). All plans for the preventing the transmission of TB shall conform to the most current CDC Guidelines for Preventing the Transmission of Mycobacterium Tuberculosis in Healthcare Settings; and~~
3. Work restrictions shall be placed on personnel who are known to be affected with any disease in a communicable stage. Such individuals shall not work in any area in any capacity in which there is the likelihood of transmitting disease to patients, personnel or other individuals within the hospice or a potential of contaminating food, food contact surfaces, supplies or any surface with pathogenic organisms.

II. Complaints

Each agency shall keep a record of complaints received. Documentation shall include the name of the complainant, the relationship to the patient, the nature of the complaint, and the action taken to resolve the complaint.

III. Informed Consent.

An informed consent shall be signed by the patient or patient's representative for provision of hospice care.

IV. Certification of Terminal Illness

The agency shall have certification signed by the attending physician and medical director or physician designee stating the patient has a terminal illness.

M. Election of Hospice Care

1. Duration of election. An election to receive hospice care shall be considered to continue as long as the patient remains in the care of a hospice or does not revoke the election for hospice care and remains certified as appropriate for hospice.
2. Effective date of election. A patient or patient's representative may designate an effective date for the election period that begins with the first day of hospice care.
3. Waiver of other benefits. A patient or patient's representative can elect hospice care from only one hospice provider at any given time.

N. Elements of the Election Statement. The election statement shall include the following:

1. Identification of the hospice that provides care to the patient;
2. The patient's or the patient's representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care, as it relates to the patient's terminal illness;
3. The effective date of the election; and
4. The signature of the patient or patient's representative.

O. Revoking the Election of Hospice Care

1. A patient or patient's representative may revoke the patient's election of hospice care at any time during an election period.
2. To revoke the election of hospice care, the patient or patient's representative shall file a statement with the hospice that includes the following information:
 - a) A signed statement that the patient or patient's representative revokes the patient's election for hospice care.
 - b) The date the revocation is effective. (A patient or patient's representative may not designate an effective date earlier than the date that the revocation is made.)

SECTION 9: QUALITY IMPROVEMENT (QI)

- A. The organization shall develop, implement, and maintain an ongoing program to assess and improve the quality of care and services provided. A Quality Improvement (QI) plan shall be developed and maintained to describe the manner in which QI activities shall be conducted. The QI plan shall be reviewed and approved by the Medical Staff and Governing Body annually.
1. All hospice programs, services, departments and functions, including contracted services related to patient care, shall participate in ongoing quality improvement activities.
 2. The hospice shall collect and assess data on the functional activities identified as priorities in the QI plan.
 3. Improvement strategies shall be developed for programs, services, departments and functions identified with opportunities for improvement.
 4. The effectiveness of improvement strategies and actions taken shall be monitored and evaluated, with documentation of conclusions regarding effectiveness.
- B. The QI program shall include, but not be limited to, ongoing assessment and improvement activities regarding the following:
1. Access to care, processes of care, outcomes of care and hospice-specific clinical data;
 2. Customer satisfaction (patients and families, physicians, and employees).

SECTION 10: INFECTION CONTROL

Each hospice shall develop an infection control program which protects patients, family and personnel from nosocomial or community acquired infections.

- A. The hospice shall develop and use a coordinated process that effectively reduces the risk of endemic and epidemic nosocomial infections in patients, health care workers and visitors.
- B. It shall be the duty of the Administrator or his/her designee to report all known infectious or communicable diseases as required by Ark. Code Ann. § 20-7-109 to the Arkansas Department of Health ~~and Human Services and Human Services~~, Division of Epidemiology.
- C. There shall be policies and procedures establishing and defining a comprehensive Infection Control program to include:
 - 1. Provisions for education of universal precautions to patients, families, and hospice employees including but not limited to:
 - a) Hand hygiene including procedures for soap and water as well as alcohol based hand rub if used;
 - b) Disinfections;
 - c) Liquid and solid waste disposal of infectious waste;
 - d) Needle disposal; and
 - e) Other means of limiting the spread of contagion.
 - 2. A plan for monitoring and evaluating all aseptic and sanitation techniques employed in the hospice to ensure that approved infection control procedures are followed.
- D. There shall be an orientation program for all new health care workers concerning the importance of infection control and each health care worker's responsibility in the infection control program.
- E. There shall be a plan for each employee to receive annual in-services and educational programs as indicated based on assessments of the infection control process.

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- F. No items shall be used past the expiration date.
- G. One-time patient care items shall not be reused.

SECTION 11: PHYSICIAN SERVICES

A. Medical Director

The overall responsibility for the medical component of patient care shall be under the direction of a physician, qualified by training and experience in hospice care, who shall also be responsible for no less than the following:

1. Ensuring and maintaining quality standards of medical practice;
2. Achievement and maintenance of quality assurance of medical practices through a mechanism for the assessment of patient/family care outcomes;
3. Certification of terminally ill patients admitted to the hospice program;
4. Participation as a member of the interdisciplinary team in the development, implementation and assessment of the patient/family plan of care; and
5. Consulting with the attending physician regarding patient care plans.

B. Physician Services

1. Physician Services shall be provided in accordance with hospice policies.
2. Such policies shall include provisions governing the relationship of the staff physicians, attending physician and the Medical Director to each other, and to the interdisciplinary team.
3. In addition to palliation and management of the terminal illness and related conditions, physician employees of the hospice, including the physician member(s) of the interdisciplinary group, must also meet the general medical needs of the patients to the extent that these needs are not met by the attending physician.

SECTION 12: NURSING SERVICES

- A. A registered nurse shall assign the nursing care of each patient to other personnel in accordance with the patient's needs.
- B. A registered nurse shall plan, supervise and evaluate the care for each patient.
- C. Nursing services shall be provided in accordance with recognized standards of practice.

SECTION 13: INTERDISCIPLINARY GROUP

The Interdisciplinary Group or groups shall be composed of individuals who provide or supervise the care and services offered by the hospice.

A. Composition of the Interdisciplinary Group

The Interdisciplinary Group or groups shall include at least the following individuals:

1. A doctor of medicine or osteopathy;
2. A registered nurse;
3. A social worker; and
4. A pastoral or other counselor.

B. Role of the Interdisciplinary Group

The Interdisciplinary Group shall:

1. Participate in the establishment of the plan of care;
2. Provide supervision of hospice care and services;
3. Periodically review and update the plan of care to reflect the needs of each patient receiving hospice care.

SECTION 14: VOLUNTEERS

The hospice shall use volunteers, in defined roles, under the supervision of a designated hospice employee. The hospice shall maintain documentation of active and ongoing efforts to recruit and retain volunteers.

A. Training

Orientation and training shall be provided consistent with acceptable standards of hospice practice.

B. Role

Volunteers may be used in administrative services or direct patient care.

C. Level of Activity

A hospice shall maintain a volunteer staff sufficient to provide administrative or direct patient care at a minimum that equals five percent of the total patient care hours of all paid hospice employees and contract staff. The hospice shall maintain a continuing level of volunteer activity. Expansion of care and services achieved through the use of volunteers, including the type of services, and the time worked, shall be recorded.

D. Employees as Volunteers

Hospice employees may be used as volunteers only after completing a hospice volunteer training program.

SECTION 15: COUNSELING SERVICES

Counseling services shall be available to the patient and the family and shall include the following:

A. Bereavement Services

There shall be an organized program for provision of bereavement services under the supervision of an individual with specialized bereavement training. The plan of care for these services shall reflect family needs which shall include personal visits up to one year following the patient's death. Refusal or variations from the visits or contacts shall be documented.

B Dietary Counseling

A qualified dietitian shall provide dietary counseling, when required.

C. Spiritual Counseling

The hospice shall notify the patient of the opportunity for spiritual counseling either from the hospice pastoral counselor or clergy of the patient's choice. If the patient elects to have his/her clergy visit, the hospice shall make reasonable efforts to arrange for the visit(s).

D. Social Services

Social Services shall be provided by a qualified Social Worker.

SECTION 16: OTHER SERVICES

A hospice shall ensure the following services are available and provided directly by hospice employees or under arrangement and offered in a manner consistent with acceptable standards of practice:

- A. Physical Therapy;
- B. Occupational Therapy; and
- C. Speech-Language Pathology.

SECTION 17: HOSPICE AIDE AND HOMEMAKER SERVICES

- A. Hospice aide services shall be available and adequate in frequency to meet the needs of the patient. A hospice aide is a person who meets at least one of the following requirements:
1. Has at least one year of experience in an institutional setting (home health agency, hospital, hospice, or long-term care facility). This experience shall be verified by a previous employer;
 2. Has a certificate issued by the State of Arkansas for work in long-term care facilities. A copy of this certificate shall be available for review; or
 3. Has completed a 40-hour aide training course that meets requirements set forth in these ~~regulations~~ rules. In lieu of the requirement for completion of the hospice aide training course, a nursing student may qualify as a hospice aide by submitting documentation from the Director of Programs and/or the Dean of a School of Nursing that reflects the nursing student has demonstrated competency in providing basic nursing care in accordance with the school's curriculum.
- B. Any aide who has not been employed as an aide in an institutional setting in the last 24 months shall be observed by a registered nurse performing the skills required to care for a patient including bathing, transferring, range of motion exercises, toileting, dressing, nail care and skin care. The registered nurse shall observe the aide performing these skills on a person. Any other tasks or duties for which the aide may be responsible shall be evaluated by written test, oral test or observation. There shall be documentation by the agency to show evidence of this evaluation.
- C. A registered nurse shall complete an aide assignment sheet for each patient receiving aide services. Each aide caring for the patient shall receive a copy of the assignment sheet and provide services as assigned. A copy of the assignment sheet shall be left in the patient's home and in the patient's medical record.
- D. Each aide assignment sheet shall be individualized and specific according to the patient's needs.
- E. The registered nurse shall conduct a visit to the patient's place of residence at least every two weeks to supervise the aide and update the aide assignment sheet.

- F. In no event shall a hospice aide receive or write verbal orders from a physician. A hospice aide shall not perform any sterile procedure or any procedure requiring the application of medication requiring a prescription.
- G. Upon a request by a patient and/or family member for assistance with medications, the registered nurse may assign a hospice aide to assist with oral medications, which are normally self-administered. Assistance shall be limited to reminding a patient to take a medication at a prescribed time, opening and closing a medication container and returning a medication to a proper storage area.
- H. Except as otherwise provided in these rules, duties of the hospice aide may include:
 - 1. Personal care (example: bathing, grooming, feeding, ambulation, exercise, oral hygiene, and skin care, etc.);
 - 2. Assistance with medications ordinarily self-administered as assigned;
 - 3. Household services essential to health care in the home;
 - 4. Completion of records and reporting to appropriate supervisor;
 - 5. Taking and charting vital signs;
 - 6. Extension of therapy services; and
 - 7. Any duty consistent with the State Board of Nursing Regulations on Delegation of Duties may be assigned by a registered nurse to meet the needs of the patient.
- I. If the training is provided by the agency, the training program for hospice aides shall be conducted under the supervision of a registered nurse. The training program may contain other aspects of learning, but shall include the following;
 - 1. A minimum of 40 hours of classroom and clinical instruction related particularly to the hospice setting;
 - 2. Written course objectives with expected outcomes and methods of evaluation;
 - 3. An assessment that the student knows how to read and write and to carry out directions; and

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4. Orientation to hospice philosophy, bathing, ambulation and exercise, personal grooming, principles of nutrition and meal preparation, health conditions, developmental stages and mental status, household services essential to health care at home, assistance with medication, safety in the home, completion of appropriate records and reporting changes to appropriate supervisor.
- J. Aides shall receive a minimum of 12 hours in-service training per 12 months. The in-services provided shall address areas that directly relate to the patient care aspects of the aides' job.
- K. Homemaker services shall be available and adequate in frequency to meet the patient's needs.

SECTION 18: PLAN OF CARE

A written plan of care shall be established, maintained, and provided for each patient admitted to a hospice program. The plan shall include an assessment of the patient's needs and identification of the services including the management of discomfort and symptom relief. It shall state in detail the scope and frequency of services needed to meet the patient's and family's needs. A written plan of care shall be:

- A. Developed by the attending physician, the medical director or physician designee and interdisciplinary group prior to providing care; and
- B. Reviewed and revised to reflect the patient and family's current needs, by the attending physician, the medical director or physician designee, and interdisciplinary group. The reviews shall be documented.
- C. Content of plan. The plan must include assessment of the individual's needs and identification of the services including the management of discomfort and symptom relief. It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

SECTION 19: CLINICAL RECORDS

In accordance with accepted principles of practice, the hospice shall establish and maintain a clinical record for every patient receiving care and services. The record shall be complete, accurate readily accessible and systematically organized to facilitate retrieval.

A. Content

Entries shall be made for the day services are provided and filed within seven days. Entries shall be signed by the person providing the services. All entries shall be legible and readily accessible. The record shall include all services whether furnished directly or under arrangement. Each patient's record shall contain the following:

1. Initial and subsequent assessments;
2. Plan of care;
3. Identification data;
4. Consent, authorization and election forms;
5. Pertinent medical history; and
6. Documentation of all services and events.

B. Protection of Information

The hospice shall use reasonable precautions to safeguard the clinical record against loss, destruction and unauthorized use.

C. Record Retention

Closed records shall be retained for a minimum of five years.

SECTION 20: MEDICAL SUPPLIES / MEDICATIONS

Medical supplies, appliances, drugs and biologicals, shall be provided as needed for the palliation and management of the terminal illness and related conditions.

A. Administration

All drugs and biologicals shall be administered in accordance with accepted standards of practice.

B. Controlled Drugs in the Patient's Home

Controlled substances no longer required by a patient receiving in-home hospice services may be disposed of by the owner of the prescription or a family member of a deceased patient to whom the controlled substances were dispensed. If requested, the controlled substances may be disposed of in the presence of a hospice nurse in which case the nurse shall document the disposal by completing the Report of Drugs Surrendered Form and returning it to Pharmacy Services and Drug Control, Arkansas Department of Health ~~and Human Services and Human Services~~. The patient or family member shall keep the blue copy of the Report of Drugs Surrendered Form while the nurse places the yellow copy in the medical record and returns the white copy to Pharmacy Services and Drug Control, Arkansas Department of Health ~~and Human Services~~.

C. Administration of Pharmaceuticals

A licensed nurse, physician, patient or caregiver shall administer pharmaceuticals.

SECTION 21: SHORT-TERM INPATIENT CARE

Inpatient care shall be available for pain control, symptom management, respite purposes, and shall be provided in licensed facilities, as stated below:

A. Inpatient Care for Symptom Control

Inpatient care for pain control and symptom management shall be provided in one of the following:

1. A hospice that meets the requirements for providing inpatient care directly as specified in the Section, 22 “Inpatient Direct Care.”
2. A hospital or a Skilled Nursing Facility (SNF).
3. Each shift shall include a registered nurse on site to supervise and provide direct patient care.

B. Inpatient Care for Respite Purposes

Inpatient care for respite purposes shall be provided by one of the following:

1. A hospice that meets the requirements for providing inpatient care directly as specified in the Section, “Inpatient Direct Care”, Section 22.
2. A hospital, skilled nursing facility (SNF), or nursing facility (NF).

SECTION 22: IN-PATIENT DIRECT CARE

In addition to the preceding sections, In-patient Direct Care shall also comply with Sections 22 through 34.

A. Administration shall be responsible for the following:

1. Policies and procedures shall be provided for the general administration of the institution and for each department, section or service in the facility. All policies and procedures for departments or services shall have evidence of ongoing review and/or revision. The first page of each manual shall have the annual review date, signature of the department supervisor and/or person(s) conducting the review.
2. The facility shall have visitation policies determined by the Medical Staff, Governing Body and Administration.
 - a) Patients shall be permitted to receive visitors at any hour, including small children.
 - b) Visitation restriction may include:
 - 1) When the presence of a visitor would be medically or therapeutically contraindicated;
 - 2) If the person has signs or symptoms of a transmittable disease
 - The facility shall allow access through telephone, telecommunications, or other means when visitation is restricted by 1) or 2);
 - 3) At the request of the patient, law enforcement or court order;
 - 4) If the presence of a visitor would interfere with the care of or rights of any patient;
 - 5) If the person is determined to be a danger to staff, other patients, or visitors; non-compliant with healthcare facility policies; or engaging in disruptive, threatening, or violent behavior toward any staff member, patient, or other visitor.
3. Disaster Preparedness

A written disaster preparedness plan shall be developed and communicated to staff through orientation, education and ongoing reviews. The plan shall include:

- a) A definition of “disaster” for the hospice inpatient facility’s given

location and circumstances;

- b) Arrangements for prompt identification and transfer of patients and records to another facility if necessary;
- c) Arrangements for coordination of community resource; and
- d) Menus to coincide with a 24-hour supply of perishable and 72 hours supply for non-perishable food available for emergencies.

B. Nursing

- 1. The facility shall provide 24 hour nursing service sufficient to meet patient needs in accordance with the patient plan of care. Each patient receives treatments, medications, and diet as prescribed, and is kept comfortable, clean, well-groomed, and protected from accident, injury, and infection.
- 2. Each shift shall include a registered nurse on site to supervise and provide direct patient care and one other nursing personnel type (e.g. RN, LPN and/or hospice aide.) A ratio of at least 1 nursing personnel to each 4 patients shall be maintained from 7 A.M. to 7 P.M. and a ratio of 1 to 6 from 7 P.M. to 7 A.M.
- 3. A registered nurse shall assign the patient care of each patient to other nursing personnel in accordance with the patient's needs.

C. Dietary

Meal service, menu planning and supervision. The hospice shall:

- 1. Serve at least three (3) meals or their equivalent each day at regular times, with not more than fourteen (14) hours between an evening meal and breakfast. Meals may be adjusted according to the request and as tolerated by the patient.
- 2. Procure, store, prepare, distribute and serve all food under sanitary conditions in accordance with the current Rules ~~and Regulations~~ Pertaining to Retail Food Establishments.
- 3. Employ a registered dietician or have a formal agreement with a registered dietician who is responsible for:
 - a) Planning menus that meet nutritional needs of each patient, in accordance with the recommended dietary allowances of the Food

Nutrition Board of the National Research Council, National Academy of Sciences; and

- b) Supervising the meal preparation and service to ensure the menu plan is followed.
- 4. Have menus prepared by a registered dietitian for patients who require medically prescribed special diets.
- 5. Have bedtime and between meal snacks or supplements available.

D. Pharmaceutical Service

Appropriate methods and procedures for the dispensing and administering of drugs and biologicals shall be developed. Whether drugs and biologicals are obtained from community or institutional pharmacists or stocked by the facility, the facility is

responsible for drugs and biologicals for patients, in so far as they are covered under the program and for ensuring that pharmaceutical services are provided in accordance with accepted professional principles and appropriate Federal, State and local laws.

1. In facilities that obtains drugs and biologicals from community or institutional pharmacies:
 - a) The Hospice shall have contractual arrangements to ensure services are available 24 hour 7 days a week to the patients in the Hospice facility.
 - b) All prescription medications in the facility shall be patient specific and appropriately labeled.
 - c) No prescription drug floor stock shall be allowed in the facility.
2. The Hospice shall:
 - a) Employ a licensed pharmacist; or
 - b) Have a formal agreement with a licensed pharmacist to advise the hospice on ordering, storage, administration, disposal, and record keeping of drugs and biologicals; and
 - c) Have a Pharmaceutical Service Committee which meets quarterly consisting of at least the Medical Director, Pharmacist, Nurse Manager, and Administrator. The committee shall be responsible for the following:
 - 1) Serve as an advisory group to the medical staff;
 - 2) Approve the policies and procedures for pharmaceutical service annually;
 - 3) Approve medication formulary annually;
 - 4) Approve floor stock annually; and
 - 5) Discuss medication errors and adverse drug reactions.

3. Orders for Medications

- a) All medications shall be ordered by the physician or credentialed licensed practitioner according to their scope of practice if approved by the Medical Staff and Governing Body.
- b) If the medication order is verbal:
 - 1) The physician shall give the order only to a licensed nurse, pharmacist, or another physician; and
 - 2) The individual receiving the order shall record and sign immediately. The prescribing physician shall sign in the time frame determined by hospice policy.

4. Administration of Medication

Medications shall be administered only by one of the following individuals:

- a) Licensed personnel in accordance with their scope of practice; and
- b) The patient with approval of the attending physician and according to hospice policy.

5. Control and Accountability

The pharmaceutical service has procedures for control and accountability of all drugs and biologicals throughout the facility. Drugs are dispensed in compliance with Federal and State laws. Records of receipt and disposition of all controlled drugs are maintained in sufficient detail to enable an accurate reconciliation. The pharmacist determines drug records are in order and an account of all controlled drugs is maintained and reconciled.

6. Labeling of Drugs and Biologicals

The labeling of drugs and biologicals is based on currently accepted professional principles and includes the appropriate accessory and cautionary instructions, as well as the expiration date when applicable.

7. Storage

In accordance with State and Federal laws, all drugs and biologicals are locked and stored under proper temperature controls and only authorized personnel shall have access to the keys. Scheduled drugs shall be maintained as required by Federal and State regulations.

8. Drug Disposal

Controlled substances no longer required by a patient residing in an inpatient hospice shall be disposed of by returning unused medications and a Report of Drugs Surrendered Form to Pharmacy Services and Drug Control, Arkansas Department of Health, ~~and Human Services and Human Services.~~

E. Linen.

The hospice has available at all times a quantity of linen essential for proper care and comfort of patients. Linens are handled, stored, processed, and transported in such a manner as to prevent the spread of infection.

F. Pet Therapy

Therapy animals (Birds, cats, dogs, and other animals) may be permitted to visit in the patient's room and shall not negatively affect the well being of others. Animals shall have appropriate vaccinations and licenses. A veterinary record shall be kept on all therapy animals to verify vaccinations and be made readily available for review. Therapy pets shall not be allowed in food preparation, food storage, dining or service areas.

G. If personal pets are allowed in the facility the facility will have policy and procedures consistent with local ordinances.

SECTION 23: INFECTION CONTROL for IPU

- A. There shall be a comprehensive list of communicable diseases for which patients shall be isolated and for which there are visitation restrictions. The list, and other policies and procedures for isolation, shall conform to the latest edition of the Centers for Disease Control and Prevention, (CDC) Guidelines.
- B. There shall be policies and procedures established and followed for:
 - 1. Sterilization;
 - 2. Sanitary food preparation;
 - 3. Housekeeping
 - 4. Linen Care;
 - 5. Separation of clean from dirty process; and
 - 6. Use of disinfectants, antiseptics and germicides according to the manufacturer's directions.

SECTION 24: PHYSICAL ENVIRONMENT.

- A. A homelike setting design and functional program shall include the following:
1. A place where all family members, including children, may come and go in a natural, family-like manner;
 2. Social areas where family members may bring food and dine together and enjoy music, games, and other activities common to the family unit; and
 3. A balance between privacy and opportunity for social interaction.
 4. Patients Areas: Bedrooms, dining areas, lounges, and surroundings shall be designed to promote privacy and dignity for the patient and family. The interior design of patient use areas shall consider lighting, the use of finish materials, furniture arrangement, and equipment to create a home like ambience without compromising the ability of caregivers to attend to the needs of the patient. Patient toilet rooms shall be accessible and provide adequate space for staff assistance in wheelchair transfers as necessary for at least 50% of patient capacity.
- B. Building and Grounds.
1. The building and equipment shall be maintained in a state of good repair at all times.
 2. Facilities and their premises shall be kept clean, neat and free of litter, and rubbish. The facility shall have written policies and procedures for housekeeping.
 3. Rooms for gas fired equipment shall not be used for storage except for noncombustible materials.
 4. Portable equipment shall be supervised by the department having control of such equipment and shall be stored in areas which are not accessible to patients, visitors, or untrained personnel.
 5. Corridors, attics, and passageways shall be free of storage. Exits shall not be blocked by storage of furniture or equipment at any time.

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6. Each hospice facility shall develop a written preventive maintenance plan including all electrically powered patient care equipment, physical plant equipment and fire alarms and detection systems. This plan shall be available to the Department for review at any time. Such plans shall provide for maintenance as recommended by the manufacturer, applicable codes, or designer and ensure that equipment and systems perform properly and safely.
7. Hand washing stations shall be available in visitors' rest rooms and for use by staff personnel.
8. A supply of hot water for patient use shall be available at all times within the range of 110° - 120°. A weekly hot water temperature log shall be maintained.
9. Heating, ventilating and air-conditioning (HVAC) systems shall be operated and maintained in a manner to provide a comfortable and safe environment for patients, personnel, and visitors. An air filter change out log shall be maintained.
10. Steam and Hot Water Systems and Pressure Vessels.

All pressure vessels shall meet the requirements of the Arkansas Boiler Inspector, Arkansas Department of Labor. 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. Maintenance and Engineering.

Emergency Procedures Program (EPP). There shall be written emergency procedures or a disaster management plan for utility system disruptions or failures which address the specific and concise procedures to follow in the event of a utility system malfunction or failure of the water supply, hot water system, medical gas system, sewer system, bulk waste disposal system, natural gas system, commercial power system, communication system, boiler or steam delivery system. These procedures shall be kept separate from all other policy and procedure manuals as to facilitate their rapid implementation. These procedures shall contain but are not limited to the following information:

1. A method of obtaining alternative sources of essential utilities;
2. A method of shutoff and location of valves for malfunctioning systems;
3. A method of notification of hospice staff in affected areas;

4. A method of obtaining repair services.

D. Environmental Services.

Solutions, cleaning compounds, disinfectants, vermin control chemicals, and all other potentially hazardous substances that are used in connection with environmental services shall be:

1. Kept in containers which accurately reflect at least the following:
 - a. Content name;
 - b. Concentration of solution;
 - c. Expiration date and lot number;
2. Stored in a secured area. Under no circumstances shall these substances be stored in or near food storage or food preparation areas;

E. Laundry Services.

1. Facility laundry service:
 - a. Sorting of soiled laundry shall be done in a designated area;
 - b. Tables or bins shall be provided for sorting of soiled laundry;
 - c. Lint traps shall be provided on dryers and shall be cleaned regularly;
 - d. Pre-rinsing shall be done in the laundry service not in showers, bathtubs or lavatories;
 - e. Removal of solid soil shall be done in soiled utility rooms or rooms that are designated for this purpose;
 - f. Patient clothing may be washed in the patient area if a separate equipped laundry room is available;
 - g. A rinsing sink shall be provided in the soiled linen area of the laundry;

SECTION 25: PHYSICAL FACILITIES

A. General Considerations.

1. The requirements set forth herein have been established by the Department and constitute minimum requirements for the design, construction, renovation, and repair of facilities requiring licensure under these ~~regulations~~ rules.
2. Facilities shall be accessible to the public, staff, and patients with physical disabilities.
3. Projects involving existing facilities shall be programmed and phased to minimize disruption of the existing functions. Access, exits and fire protection shall be maintained for the occupant's and the facility's safety.
4. Codes and Standards. Nothing stated herein shall relieve the owner from compliance with building codes, ordinances, and regulations which are enforced by city, county, or other State jurisdictions. Where such codes, ordinances, and ~~regulations~~ rules are not in effect, the owner shall consult the state building codes for all components of the building type which are not specifically covered by these minimum requirements.

B. Occupancy: Each licensed facility or portion of a licensed facility shall be classified as indicated below:

In-patient Direct Care Hospice: In-patient Direct Care Hospice means a licensed hospice facility that provides direct in-patient care to the terminally ill.

C. Multiple Occupancy: Facilities may contain more than one provided each different occupancy is separated from all other occupancies by a 2-hour fire resistive rated smoke barrier.

D. Construction Projects: Each construction project shall be classified as indicated below:

1. New
2. Addition: A project that increases the floor area of a licensed facility.
3. Repair: A project that provides for the repair or renewal of a licensed facility or portion of a licensed facility solely for the purpose of its maintenance.

4. Simple Renovation: A project other than repair that meets all of the criteria listed below:
 - a. The project does not increase the floor area of a licensed facility.
 - b. The project does not change the occupancy of a licensed facility or portion of a licensed facility.
 - c. The project does not involve more than two (2) smoke compartments.
 - d. The smoke compartments affected by the project were completely protected by an automatic sprinkler system prior to the project or the project provides for the installation of a complete automatic sprinkler system in all smoke compartments that are affected by the project.
5. Complex Renovation: A project other than Addition, Repair, or Simple Renovation.

E. Applicable Requirements Based upon Occupancy:

Existing Facilities: Existing facilities that do not comply with these ~~regulations~~ rules shall be permitted to continue in service, provided the lack of conformity with these ~~regulations~~ rules does not present a serious hazard to the occupants as determined by Health Facility Services or other authorities having jurisdiction.

F. Applicable Requirements Based upon the Type of Project:

1. General:

- a. Where renovation work is done within an existing facility, all new work, or additions, or both, shall comply, insofar as practical with applicable sections of these ~~regulations~~ rules and appropriate sections of National Fire Protection Association (NFPA) 101 Life Safety Code covering new occupancies.
- b. In renovation projects and projects involving additions to existing facilities, only that portion of the total facility affected by the project shall comply with applicable sections of these ~~regulations~~ rules and with appropriate parts of NFPA 101 covering new occupancies. Existing portions of the facility that are not included in the project but essential to the functioning of a complete facility shall comply (at a minimum) with the appropriate sections of NFPA 101 covering existing occupancies. Existing portions of the facility that receive less than

substantial amounts of new work, shall also comply (at a minimum) with the appropriate sections of NFPA 101 covering existing occupancies.

- c. Facilities or portions of facilities shall be permitted to be occupied during construction, renovation, and repair only where required means of egress and required fire protection features are in place and continuously maintained for the portion occupied or where alternate life safety measures acceptable to the Division and other authorities having jurisdiction are in place.
2. New, Addition, Simple Renovation, and Complex Renovation shall be designed, constructed, and renovated in accordance with the applicable Sections of these ~~regulations~~ rules and all Appendices and publications referenced by these Sections.
3. Repair projects shall be designed and constructed in a manner that does not diminish the safety level that existed prior to the start of the work.

G. Project Review and Approval Process.

1. Coordination: Health Facilities Services will coordinate the review and approval process for all offices of the Department.
2. New, Addition, Simple or Complex Renovation Projects shall be reviewed and approved by the Division as indicated below:
 - a. Drawing Review and Approval Process:
 - 1) Submission of Plan Review Fee: A plan review fee in the amount of one percent of the total cost of construction or \$500.00, whichever is less, shall be paid for the review of plans and specifications. The plan review fee check is to be made payable to the Arkansas Department of ~~Health and Human Services~~. A detailed estimate shall accompany the plans unless the maximum fee of \$500.00 is paid.
 - 2) Submission of Functional Program and Cost Estimate.
 - 3) Submission of Site Location.
 - 4) Submission of Preliminary Plans.

- 5) Review of functional program, site location, and preliminary plans: Health Facility Services shall review the functional program, site location, and preliminary plans and forward a written response with comments to the Facility.
 - 6) Submission of Final Construction Documents.
 - 7) Review and Approval of Final Construction Documents: Health Facility Services shall review the final construction documents and forward a written response with comments to the Facility. Health Facility Services shall have a minimum of six (6) weeks to review final construction Documents. The written response shall indicate whether or not the final construction documents are approved. If the final construction documents are not approved, the written response shall indicate the design modifications required to secure approval.
- b. Approval to Begin Construction: Facilities may proceed with New construction, Addition, Simple or Complex renovation projects after receiving a letter from Health Facility Services stating that the final construction documents have been reviewed and approved and after receiving approval from other authorities having jurisdiction.
 - c. Site Inspections During Construction.
 - d. Final Site Inspection.
3. Repair: Repair projects do not require Health Facility Services review and approval.

H. Site Location.

1. Roads and Parking.
 - a. Paved roads and walks shall be provided within the lot lines to provide access to the main entrance and service entrance, including loading and unloading docks for delivery trucks. Paved walkway shall be provided for necessary pedestrian traffic.

- b. Each facility shall have parking spaces to satisfy the minimum needs of patients, employees, staff, and visitors. In the absence of a formal parking study, each facility shall provide not less than one space for each day shift staff member and one space for each patient bed. This ratio may be reduced in an area convenient to a public transportation system or to a public parking facility if proper justification is given and provided that approval of any reduction is obtained from the Department.
 2. Subsoil Investigation. Subsoil investigation shall be made to determine the subsurface soil and water conditions. The investigation shall include a sufficient number of test pits or test borings to determine, in the judgment of the architect and the structural engineer, the true subsurface conditions. Results of the investigation shall be available in the form of a soil investigation report or a foundation engineering report. The investigation shall be made in close cooperation with the architect and structural engineer and shall contain detailed recommendations for foundation design and gradings.
 3. Approval. The new building site shall be inspected and approved by the Department before construction begins.
- I. Preliminary Plans: Preliminary plans submitted to the Division shall include as a minimum the following information:
 1. Floor plans drawn to scale that indicate room names, room dimensions, corridor dimensions, locations of fire resistive rated partitions, and locations of rated smoke barriers.
 2. An existing floor plan indicating existing spaces and exits and their relationship to the new construction (renovation projects only).
 3. Building sections that establish the proposed construction type and fire rating. Sections shall be drawn at a scale sufficiently large to clearly present the proposed construction system.
 4. A site plan that indicates the location of proposed roads, walks, service and entrance courts, parking, and orientation.
 5. Simple horizontal and vertical space diagrams that indicate the relationship of various departments and services to each other and the general room arrangement in each department.

6. A narrative description of proposed mechanical, electrical, and fire protection systems.
- J. Final Construction Documents.
1. Construction Documents shall be prepared by an architect and/or professional engineer licensed by the State of Arkansas.
 2. Architectural construction documents shall be prepared by an architect and engineering construction documents (structural, mechanical, electrical, and civil) shall be prepared by a qualified engineer. The documents shall be stamped with appropriate seals for each discipline.
 3. Periodic observations of construction shall be provided and documented by each design professional. Design professionals shall verify that the construction is in accordance with the construction documents and that the Record Drawings are properly maintained.
 4. The construction contract shall contain a provision to withhold progress payments to the contractor until the Record Drawings are current.
 5. Final Construction Documents shall include drawings and specifications. Separate drawings and specifications shall be prepared for each of the following branches of work: architectural, structural, mechanical, electrical, life safety and fire protection.
 - a. Specifications: Specifications shall supplement the drawings to fully describe types, sizes, capacities, workmanships, finishes, and other characteristics of all materials and equipment and shall include the following:
 - 1) Cover or title sheet with architectural seal;
 - 2) Index;
 - 3) General conditions;
 - 4) General requirements;
 - 5) Sections describing material and workmanship in detail for each class of work.

- b. All construction documents and specifications shall be approved by the Department prior to the beginning of construction and a letter shall be issued from the licensing agency granting approval to commence with construction. The Department shall have a minimum of six (6) weeks to review construction documents and specifications. Health Facility Services shall coordinate the plan review with other Divisions in the Department.
- K. Site Inspection During Construction. The Department shall inspect the project during the construction process as indicated below:
 - 1. This Department is to be notified when construction begins and a construction schedule shall be submitted to determine inspection dates.
 - 2. Representatives from the Department shall have access to the construction premises and the construction project for purposes of making whatever inspections deemed necessary throughout the course of construction.
 - 3. Any deviation from the accepted construction documents shall not be permitted during construction, until the written request for change(s) in the construction is approved by the Department.
- L. Final Site Inspection.
 - 1. Upon completion of construction and prior to the approval by the Department to occupy and use the facility, the owner shall be furnished a complete set of Record Drawings and a complete set of installation, operation, and maintenance manuals and parts lists for the installed equipment.
 - 2. A list of final site inspection items has been provided in Table 5 of the Appendix.
 - 3. No facility shall occupy any new structure or major addition or renovation space until the appropriate permission has been received from the local building and fire authorities and licensing agency.

SECTION 26: PHYSICAL FACILITIES, PATIENT ACCOMMODATIONS FOR HOSPICE FACILITIES

A. Patient Rooms. Each patient room shall meet the following requirements.

1. Maximum room capacity shall be two patients.
2. In new construction, patient rooms shall have a minimum of 100 square feet of clear floor area per bed in semi-private rooms and 120 square feet of clear floor area for single-bed rooms, exclusive of toilet rooms, closets, lockers, wardrobes, alcoves or vestibules. The dimensions and arrangement of rooms shall be such that there is a minimum of three feet between the sides and foot of the bed and any wall, other fixed obstruction, or another bed. In semi-private bed rooms, a clearance of four feet shall be available at the foot of each bed to permit the passage of equipment and beds.

Minor encroachments, including columns and lavatories, that do not interfere with functions may be ignored when determining space requirements for patient rooms. Where renovation work is undertaken, every effort shall be made to meet the above minimum standards.

3. Each patient room shall have a window with outside exposure and where the operation of windows or vents requires the use of tools or keys, such devices shall be on the same floor and easily accessible to staff. The windowsills shall not be higher than three feet above the floor and shall be above the grade. Patient rooms in new construction intended for 24 hour occupancy shall have windows. If operable windows are installed, such devices shall be restricted to inhibit possible escape or suicide.
4. Each patient shall have access to a toilet room without having to enter the general corridor area. One toilet room shall serve no more than four patient beds and no more than two patient rooms. In new construction, an additional hand washing station or sanitizing station shall be placed in the patient room where the toilet room serves more than one bed. The toilet room shall contain a water closet and a hand washing station and the door shall swing outward or be double acting.
5. Each patient shall have within the room a separate wardrobe or closet that is suitable for hanging full length garments and for storing personal items.

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6. Visual privacy from casual observation by other patients and visitors shall be provided for each patient in semi-private rooms with cubicle curtains or equivalent built-in or movable dividers. The method for providing privacy shall not obstruct passage of other patients either to the entrance, toilet, or lavatory. All curtains shall have a flame spread of 0 to 25 and shall comply with NFPA 13 requirements for clear space below sprinklers.
 7. Each room shall connect directly with a corridor without passage through another patient's room.
 8. Rooms existing partially below grade level shall not be used for patients unless they are dry, well ventilated, and are otherwise suitable for occupancy.
 9. Beds shall be arranged to provide adequate room for all patient care procedures and to prevent the transmission of infections.
 10. Suitable beds shall be provided. Bed rails shall be provided on beds for children.
 11. A reading light shall be provided for each patient bed. The location and design shall be such that the light is not annoying to other patients.
 12. A bedside table with drawer shall be provided for each bed. The lower portion of the table and/or enclosed shelves shall be provided for individual nursing care equipment.
 13. A bathing facility containing either a bathtub or a shower accessible to a wheeled shower chair shall be conveniently accessible to patient rooms. An accessible toilet room shall be accessible to the bathing room.
- B. Service Areas. Each service area may be arranged and located to serve more than one nursing unit but at least one such service area shall be provided on each nursing floor. Some of the service areas may be combined in a single space. The following service areas shall be located in or readily available to each nursing unit:
1. Nursing Station. Facilities for charting, clinical records, work counter, communication system, space for supplies and convenient access to hand washing stations shall be provided. It may be combined with or include centers for reception and communication;
 2. Dictation area shall be provided. This area shall be adjacent to but separate from the nurses' station;

3. Toilet room(s) for staff convenient to nurses' station (may be unisex);
4. Multi-purpose room(s) for staff, patients, patients' families for patient conferences, reports, education, training sessions, and consultation
5. Clean workroom or clean supply room. If the room is used for preparing patient care items, it shall contain a work counter, a hand washing fixture, and storage facilities for clean and sterile supplies. If the room is used only for storage and holding as part of a system for distribution of clean and sterile materials, the work counter and hand washing fixture may be omitted. Soiled and clean workrooms or holding rooms shall be separated and have no direct connection;
6. Soiled workroom or soiled holding room. This room shall be separate from the clean workroom. The soiled workroom shall contain a clinical sink (or equivalent flushing-rim fixture). The room shall contain a lavatory (or hand washing fixture). The above fixtures shall both have a hot and cold mixing faucet. The room shall have a work counter and space for separate covered containers for soiled linen and waste. Rooms used only for temporary holding of soiled material may omit the clinical sink and work counter. If the flushing-rim clinical sink is eliminated, facilities for cleaning bedpans shall be provided elsewhere;
7. Medication Station. Provisions shall be made for distribution of medications. This may be done from a medicine preparation room or unit, from a self-contained medicine dispensing unit, or by another approved system;
 - a. Medicine preparation room. This room shall be designed to allow for visual supervision by the nursing staff. It shall contain a work counter, a sink adequate for hand washing, refrigerator, and locked storage for controlled drugs. When a medicine preparation room is to be used to store one or more self-contained medicine dispensing units, the room shall be designed with adequate space to prepare medicines with the self-contained medicine dispensing unit(s) present.
 - b. Self-contained medicine dispensing unit. A self-contained medicine dispensing unit may be located at the nurses' station, in the clean workroom, or in an alcove, provided the unit has adequate security for controlled drugs and adequate lighting to easily identify drugs. Convenient access to hand washing stations shall be provided. (Standard cup-sinks provided in many self-contained units are not adequate for hand washing.)

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8. Nourishment Station. This shall contain a sink equipped for handwashing, equipment for serving nourishment between scheduled and unscheduled meals, refrigerator, storage cabinets, and ice maker units to provide ice for patients' service and treatment. Ice for human consumption shall be from self-dispensing units. Hand washing stations shall be in or immediately accessible to the nourishment station;
 9. Equipment Storage Room. This shall be for equipment such as I.V. stands, inhalators, air mattresses, walkers and wheelchairs; and
 10. A comfortable and easily accessible sleep area for family members.
- C. A common kitchen area if provided shall contain a refrigerator, sink and microwave.
 - D. Dining and/or gathering space for patients and families shall be provided as required by the narrative program.
 - E. Airborne Infection Isolation Room(s). Rooms for patients who are suffering from airborne infections shall be provided at the rate of one for each 36 beds or fraction thereof.

SECTION 27: PHYSICAL FACILITIES, PHARMACY

The size and type of services to be provided in the pharmacy can largely depend upon the type of medication distribution system used, number of patients to be served, and extent of shared or purchased services. This shall be described in the narrative functional program. The pharmacy room or suite shall be located for convenient access, staff control, and security. Facilities and equipment shall be as necessary to accommodate the functions of the program. See Section 22(D) Pharmacy for additional requirements. As a minimum, the following elements shall be included:

- A. Dispensing.
 - 1. A pickup and receiving area.
 - 2. An area for reviewing and recording.
 - 3. An extemporaneous compounding area that includes a sink and sufficient counter space for medication preparation.
 - 4. Work counters and space for automated and manual dispensing activities.
 - 5. An area for temporary storage, exchange, and restocking of carts.
 - 6. Security provisions for medications and personnel in the dispensing counter area.
- B. Manufacturing.
 - 1. A bulk compounding area.
 - 2. Provisions for packaging and labeling.
 - 3. A quality control area.
- C. Storage (may be cabinets, shelves, and/or separate rooms or closets).
 - 1. Bulk storage.
 - 2. Active storage.
 - 3. Refrigerated storage.

4. Volatile fluids and alcohol storage constructed according to applicable fire safety codes for the substances involved.
 5. Double-locked storage for controlled substances.
 6. Storage for general supplies and equipment not in use.
- D. Administration.
1. An area for education and training (may be in a multipurpose room shared with other departments).
 2. A separate area for office functions.
- E. Other.
1. Hand washing facilities stations shall be provided within each separate room where open medication is handled and readily accessible.
 2. Provide for convenient access to toilet and locker.
 3. If unit dose procedure is used, provide additional space and equipment for supplies, packaging, labeling, and storage, as well as for the carts.
 4. If IV solutions are prepared in the pharmacy, provide a sterile work area with a laminar-flow work station designed for product protection. The laminar-flow system shall include a nonhydroscopic filter (HEPA) rated at 99.97 percent, as tested by DOP tests and have a visible pressure gauge for detection of filter leaks or defects.
 5. Hoods used for chemotherapy shall be 100 percent exhausted to the exterior.
 6. As a minimum the partitions enclosing the pharmacy shall extend from the floor to the deck above, with gypsum board on both sides of metal studs.

SECTION 28: PHYSICAL FACILITIES, WASTE PROCESSING SERVICES

- A. Hazardous Waste and Antineoplastic Agent Disposal. The facility shall have policies and procedures for the identification, segregation, labeling, storage, transport and disposal of hazardous waste. The policies and procedures shall conform with the latest edition of Hazardous Waste Management Regulation 23, Arkansas Department of Environmental Quality, Little Rock, Arkansas. Within the facility, hazardous waste, especially antineoplastic agents, shall be labeled in a manner that it shall be easily recognized from all other waste. The facility shall compile a list of all antineoplastic agents used in the facility. The facility shall have policies and procedures for the clean up of spills, decontamination and treatment of personnel exposed to hazardous waste and antineoplastic agents.
- B. Regulated Medical Waste (Infectious Waste) Disposal. The facility shall have policies and procedures for the identification, segregation, labeling, storage, transport and disposal of regulated medical waste. All policies and procedures shall conform to the latest edition of the Rules ~~and Regulations~~ Pertaining to the Management of Medical Waste from Generators and Health Care Related Facilities, Arkansas Department of Health ~~and Human Services~~, Little Rock, Arkansas. The facility shall have policies and procedures for the clean up of spills, and for decontamination and treatment of personnel exposed to regulated medical waste.
- C. Solid Waste Disposal (Non-Infectious Waste). The facility shall have policies and procedures for the identification, segregation, labeling, storage, transport and disposal of solid waste. Policies and procedures shall conform with the latest edition of the Solid Waste Management Regulation 22, Arkansas Department of Environmental Quality, Little Rock, Arkansas.
- D. Other Waste. The facility shall have policies and procedures for the identification, segregation, labeling, storage, transport, and disposal of any waste not specifically mentioned in this section.

SECTION 29: PHYSICAL FACILITIES, DETAILS AND FINISHES

All details for alteration or expansion projects as well as for new construction shall comply with the following.

A. Details.

1. Compartmentation, exits, automatic extinguishing systems, and other details relating to fire prevention and fire protection shall comply with requirements listed in the NFPA referenced codes, shall be maintained at the facility and shown on the Fire Protection Plan.
2. Corridor partitions, smoke stop partitions, horizontal exit partitions, exit enclosures, and fire rated walls required to have protected openings shall be effectively and permanently identified with signs or stenciling in a manner acceptable to the Health Facility Services. Such identification shall be above any decorative ceiling and in concealed spaces.
3. Rooms containing bathtubs, sitz baths, showers, and water closets, subject to occupancy by patients, shall be equipped with doors and hardware which shall permit access from the outside the room.
4. Glass doors, lights, sidelights, borrowed lights, and windows located within 12 inches of a door jamb (with a bottom frame height of less than 60 inches above the finished floor) shall be constructed of safety glass, wired glass, or plastic, break resistant material that creates no dangerous cutting edges when broken. Safety glass-tempered or plastic glazing materials shall be used for shower doors and bath enclosures. In renovation projects, only glazing within 18 inches of the floor shall be changed to safety glass, wire glass, or plastic, break-resistant material.
5. Thresholds and expansion joint covers shall be installed flush with the floor surface to facilitate use of wheelchairs and carts. Expansion and seismic joints shall be constructed to restrict the passage of smoke.
6. Grab bars shall be provided in all patients' toilets, showers, tubs, and sitz baths. The bars shall have one and one-half inch clearance to walls and shall have sufficient strength and anchorage to sustain a concentrated load of 250 pounds.
7. Lavatories and hand washing stations shall be securely anchored to withstand an applied downward vertical load of not less than 250 pounds on the front of the fixture.

8. The minimum ceiling height shall be seven feet ten inches with the following exceptions:
 - a. Boiler rooms shall have ceiling clearances not less than two feet six inches above the main boiler header and connecting piping.
 - b. Ceilings in corridors, storage rooms, and toilet rooms shall be not less than seven feet eight inches in height. Ceiling heights in small, normally unoccupied spaces may be reduced.
 - c. Where existing structures make the above ceiling clearance impractical, clearances shall be as required to avoid injury to individuals up to six feet four inches tall.
9. Rooms containing heat-producing equipment (such as boiler or heater rooms and laundries) shall be insulated and ventilated to prevent any floor or partition surface from exceeding a temperature of ten degrees Fahrenheit above ambient room temperature.
10. Noise reduction criteria shown in Table 2 of the Appendix shall apply to partition, floor, and ceiling construction in patient areas. (Careful attention shall be given to penetrations.)
11. Light fixtures shall be provided with protective covers in food preparation, serving areas, and patient care and treatment spaces. Protective light fixture covers are not required in corridors.
12. Handrails shall be provided in all corridors used by patients.

B. Finishes.

Floors and walls penetrated by pipes, ducts, and conduits shall be tightly sealed to minimize entry of rodents and insects.

SECTION 30: PHYSICAL FACILITIES, CONSTRUCTION, INCLUDING FIRE RESISTIVE REQUIREMENTS

- A. Design. Every building and every portion thereof shall be designed and constructed to sustain all dead and live loads in accordance with American Society of Civil Engineers, (ASCE), "Minimum Design Loads for Buildings and Other Structures."
- B. Foundations. Foundations shall rest on natural solid bearing if a satisfactory bearing is available at reasonable depths. Proper soil-bearing values shall be established in accordance with recognized standards. If solid bearing is not encountered at practical depths, the structure shall be supported on drive piles or drilled piers designed to support the intended load without detrimental settlement, except that one story buildings may rest on a fill designed by a soils engineer. When engineered fill is used, site preparation and placement of fill shall be performed under the direct full-time supervision of the soils engineer. The soils engineer shall issue a final report on the compacted fill operation and certification of compliance with the job specifications. All footings shall extend to a depth not less than one foot below the estimated maximum frost line.
- C. Construction.
 - 1. Construction shall comply with the applicable requirements of NFPA 101, and the Arkansas Fire Protection Code Volumes I and II and Arkansas State Building Services, Minimum Standards and Criteria - Accessibility for the Physically Disabled Standards.

NOTE: NFPA 101 generally covers fire/safety requirements only, whereas most model codes also apply to structural elements. The fire/safety items of NFPA 101 would take precedence over other codes in case of conflict. In the event NFPA 101 does not specifically address a life safety requirement found only in the Arkansas Fire Prevention Code, compliance with the requirement is not mandatory. Appropriate application of each would minimize problems. For example, some model codes require closers on all patient doors. NFPA 101 recognizes the potential fire/safety problems of this requirement and stipulates that if closers are used for patient room doors, smoke detectors shall also be provided within each affected patient room.

- 2. For renovation projects, the extent of new construction shall be determined by the licensing agency. Construction shall comply with applicable requirements of NFPA 101.

- D. Elevators. All facilities located on other than the grade-level entrance floor shall have electric or hydraulic elevators. Elevator cars shall have inside dimensions that accommodate a patient bed with attendants. Cars shall be at least five feet eight inches wide by nine feet deep. Car doors shall have a clear opening of not less than four feet wide and seven feet high. In renovations, existing elevators that can accommodate patient beds used in the facility will not be required to be increased in size.

NOTE: Additional elevators installed for visitors and material handling may be smaller than noted above, within restrictions set by standards for disabled access.

SECTION 31: PHYSICAL FACILITIES, PLUMBING AND OTHER PIPING SYSTEMS

All plumbing systems shall be designed and installed in accordance with the requirements of the latest edition of the Arkansas State Plumbing Code and the latest edition of the Laws, Rules, and Regulations Governing Boiler Inspection, Arkansas Department of Labor.

SECTION 32: PHYSICAL FACILITIES, ELECTRICAL STANDARDS

- A. Lighting.
 - 1. Approaches to buildings and parking lots, and all occupied spaces within buildings shall have fixtures that can be illuminated as necessary.
 - 2. Patient rooms shall have general lighting and night lighting.
 - 3. Nursing unit corridors shall have general illumination with provisions for reducing light levels at night.
 - 4. Egress and exit lighting shall comply with NFPA 101.
- B. Nurse/Patient Communication Station.
 - 1. A nurse/patient communication system shall be provided for each patient bedside as in accordance with the functional program.
 - 2. An emergency call system shall be provided in each patient's toilet, bath and shower room.
- C. Emergency electrical generators shall have a minimum 48 hours of on-site fuel.
- D. All health care occupancies shall be provided with a fire alarm system in accordance with NFPA 101 and NFPA 72.

SECTION 33: SEVERABILITY

If any provision of these Rules ~~and Regulations for Hospice in Arkansas~~ or the application ~~thereof~~ to any person or circumstances is held invalid, such ~~invalidity shall not affect other~~ provisions or applications of the Rules ~~which that~~ can be given effect without the invalid provision or application will be enforced, and to this end the provisions ~~hereto of these Rules~~ are declared to be severable.

SECTION 34: SATELLITE OFFICE OR ALTERNATE DELIVERY SITE

A licensed agency shall file an application under oath with the Department upon forms prescribed by the Department prior to beginning operation of a satellite office. The Department will review the application and issue a written approval or denial of the application. A satellite office must provide the same full range of services that is required of the licensed parent hospice. The governing body and administration of the parent hospice must be able to exert the supervision and control necessary to assure that all hospice services continue to be responsive to the needs of the patient / family. Each patient of the satellite office must be assigned to a specific IDG. Current active patient records will be maintained by the satellite office but must be available to the state surveyors at the parent location if requested. Locations that do not meet these criteria will not be approved as a satellite office and must obtain a separate license.

APPENDIX

TABLE 1

Filter Efficiencies for Central Ventilation and Air Conditioning Systems in Health Care Facilities			
Area Designation	No. Filter Beds	Filter Bed No.1 (%)	Filter Bed No.2 (%)
All areas for patient care, treatment, and diagnosis, and those areas providing direct service or clean supplies such as sterile and clean processing.	2	30	90
Positive Protective Environment Room	2	30	99.97
Laboratories	1	80	-
Administrative, Bulk Storage, Soiled Holding Areas, Food Preparation Areas, and Laundries	1	30	-

Notes: The filtration efficiency ratings are based on average dust spot efficiency per ASHRAE 52-76.1 – 1992.

Additional roughing or prefilters should be considered to reduce maintenance required for filters with efficiencies higher than 75 percent.

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TABLE 2

Sound Transmission Limitations in Health Care Facilities		
	Airborne Sound Transmission Class (STC) ¹	
	Partitions	Floors
NEW CONSTRUCTION²		
Patients' Room to Patients' Room	45	40
Public Space to Patients' Room ²	55	40
Service Areas to Patients' Room ³	65	45
Patient room access corridor ⁴	45	45
Toilet room to public space	45	_____
Consultation rooms/ conference rooms to public space	45	_____
Consultation rooms/ Conference rooms to patient rooms	45	_____
Staff lounges to patient rooms	45	_____
Existing Construction		
Patient room to patient room	35	40
Public space to patient room ²	40	40
Service areas to patient room ³	45	45

1. Sound transmission class (STC) shall be determined by tests in accordance with methods set forth in ASTM Standard E90 and ASTM E413. Where partitions do not extend to the structure above, sound transmission through ceilings and composite STC performance shall be considered.
2. Public space includes corridors (except patient room access corridors), lobbies, dining rooms, recreation rooms, and similar spaces.
3. Service areas include kitchens, elevators, elevator machine rooms, laundries, and similar spaces garages, maintenance rooms, boiler and mechanical equipment rooms, and similar spaces of high noise. Mechanical equipment located on the same floor or above patient rooms, offices, nurses stations, and similar occupied space shall be effectively isolated from the floor.
6. Patient room access corridors contain composite walls with doors/windows and have direct access to patient.

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TABLE 3

Temperature and Relative Humidity Requirements		
Area Designation	Dry Bulb Temperatures °F ¹	Relative Humidity (%) Minimum-Maximum ²
Sterile Storage	75	70 (max)

¹Note: Where temperature ranges are indicated, the systems shall be capable of maintaining the rooms at any point within the range. A single figure indicates a heating or cooling capacity of at least the indicated temperature. This is usually applicable when patients may be undressed and require a warmer environment. Nothing in these guidelines shall be construed as precluding the use of temperatures lower than those noted when the patients' comfort and medical conditions make lower temperatures desirable. Unoccupied areas such as storage rooms shall have temperatures appropriate for the function intended.

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TABLE 4
Ventilation, Medical Gas, and Air Flow Requirements in Health Care Facilities¹

Area Designation	Air Movement Relationship To Adjacent Area ²	Minimum Air Changes Outside Air Per Hour ³	Minimum Total Air Changes Per Hour ^{4,5}	Air Recirculated By Means of Room Units ⁷	All Air Exhausted Directly Outdoor ⁶
NURSING AREAS					
Patient Room	-	2	6 ⁹	Optional	Optional
Toilet Room	In	-	10	Optional	Yes
Protective environment room ^{8, 10}	Out	2	12	No	Optional
Airborne Infectious Isolation ^{8, 11}	In	2	12	No	Yes
Patient Corridor	-	-	2	Optional	Optional
ANCILLARY AREAS					
Pharmacy	Out	-	4	Optional	Optional
DIAGNOSTIC AND TREATMENT AREAS					
Soiled Workroom or Soiled Holding	In	-	10	No	Yes
Clean Workroom or Clean Holding	Out	-	4	Optional	Optional
SERVICE AREAS					
Food Preparation Centers ¹²	-	-	10	No	Optional
Warewashing	In	-	10	No	Yes
Dietary Day Storage	In	-	2	Optional	Optional
Laundry, General	-	-	10	Optional	Yes
Soiled Linen Sorting and Storage	In	-	10	No	Yes
Clean Linen Storage	Out	-	2	Optional	Optional
Soiled Linen and Trash Chute Room	In	-	10	No	Yes
Bedpan Room	In	-	10	Optional	Yes
Bathroom	In	-	10	Optional	Optional
Janitor's closet	In	-	10	No	Yes

Notes for Table 4

- The ventilation rates in this table cover ventilation for comfort, as well as for asepsis and odor control in areas that directly affect patient care and are determined based on healthcare facilities being predominantly "No Smoking" facilities. Where smoking may be allowed, ventilation rates will need adjustment. Areas where specific ventilation rates are not given in the table shall be ventilated in accordance with ASHRAE Standard 62, Ventilation for Acceptable Indoor Air Quality; and *ASHRAE Handbook-HVAC Applications*. OSHA standards and/or NIOSH criteria require special ventilation requirements for employee health and safety within healthcare facilities.
- Design of the ventilation system shall provide air movement which is generally from clean to less clean areas. If any form of variable air volume or load shedding system is used for energy conservation, it shall not

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3. compromise the corridor-to-room pressure balancing relationships or the minimum air changes required by the table.
4. To satisfy exhaust needs, replacement air from the outside is necessary. Table 4 does not attempt to describe specific amounts of outside air to be supplied to individual spaces except for certain areas such as those listed. Distribution of the outside air, added to the system to balance required exhaust, shall be as required by good engineering practice. Minimum outside air quantities shall remain constant while the system is in operation.
5. Number of air changes may be reduced when the room is unoccupied if provisions are made to ensure that the number of air changes indicated is reestablished any time the space is being utilized. Adjustments shall include provisions so that the direction of air movement shall remain the same when the number of air changes is reduced. Areas not indicated as having continuous directional control may have ventilation systems shut down when space is unoccupied and ventilation is not otherwise needed, if the maximum infiltration or exfiltration permitted in Note 2 is not exceeded and if adjacent pressure balancing relationships are not compromised. Air quantity calculations shall account for filter loading such that the indicated air change rates are provided up until the time of filter change-out.
6. Air change requirements indicated are minimum values. Higher values should be used when required to maintain indicated room conditions (temperature and humidity), based on the cooling load of the space (lights, equipment, people, exterior walls and windows, etc.).
7. Air from areas with contamination and/or odor problems shall be exhausted to the outside and not recirculated to other areas.
8. Recirculating room HVAC units refers to those local units that are used primarily for heating and cooling of air, and not disinfection of air. Because of cleaning difficulty and potential for buildup of contamination, recirculating room units shall not be used in areas marked "No." However, for airborne infection control, air may be recirculated within Individual isolation rooms if HEPA filters are used. Isolation rooms may be ventilated by reheat induction units in which only the primary air supplied from a central system passes through the reheat unit.
9. Differential pressure shall be a minimum of 0.01" water gauge (2.5 Pa). If alarms are installed, allowances shall be made to prevent nuisance alarms of monitoring devices.
10. Total air changes per room for patient rooms may be reduced to 4 when supplemental heating and/or cooling systems (radiant heating and cooling, baseboard heating, etc.) are used.
11. The protective environment airflow design specifications protect the patient from common environmental airborne infectious microbes (i.e., Aspergillus spores). These special ventilation areas shall be designed to provide directed airflow from the cleanest patient care area to less clean areas. These rooms shall be protected with HEPA filters at 99.97 percent efficiency for a 0.3 micron sized particle in the supply airstream. These Interrupting filters protect patient rooms from maintenance-derived release of environmental microbes from the ventilation system components. Recirculation HEPA filters can be used to increase the equivalent room air exchanges. Constant volume airflow is required for consistent ventilation for the protected environment. If the facility determines that airborne infection isolation is necessary for protective environment patients, an anteroom shall be provided. Rooms with reversible airflow provisions for the purpose of switching between protective environment and airborne infection isolation functions are not acceptable.
12. The infectious disease isolation room described in these guidelines is to be used for isolating the airborne spread of infectious diseases, such as measles, varicella, or tuberculosis. The design of airborne infection isolation (All) rooms should include the provision for normal patient care during periods not requiring Isolation precautions. Supplemental recirculating devices may be used in the patient room, to increase the equivalent room air exchanges; however, such recirculating devices do not provide the outside air requirements. Air may be recirculated within individual isolation rooms if HEPA filters are used. Rooms with reversible airflow provisions for the purpose of switching between protective environment and All functions are not acceptable.

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12. Food preparation centers shall have ventilation systems whose air supply mechanisms are interfaced appropriately with exhaust hood controls or relief vents so that exfiltration or infiltration to or from exit corridors does not compromise the exit corridor restrictions of NFPA 90A, the pressure requirements of NFPA 96, or the maximum defined in the table. The number of air changes may be reduced or varied to any extent required for odor control when the space is not in use.

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TABLE 5
Final Occupancy Inspection Check List

Inspector: _____ Date: _____

Facility: _____ Job: _____

General Contractor: _____

The following items shall be located at the site and copies furnished to the Division of Health Facilities Services (DHFS) prior to the final inspection and approval for occupancy of the project area(s). These items are in no specific order. Some items may not apply in every case.

Item	Yes	No	Comments
1. Architect/Engineer's Certification of Substantial Completion?			
2. Interior finishes - smoke development and fire spread rating information?			
3. Fire Protection Systems- Portable fire extinguishers are inspected, and tagged, and shop drawings for standpipe/sprinkler systems are available?			
4. Certificate of Occupancy - City Building Inspector?			
5. Certification - fire alarm system, smoke detection system, sprinkler system, and any other fire suppression system has been installed, tested and meets all applicable standards?			
6. Certification - medical gas system?			
7. Certification - electrical system has been installed, tested and meets all applicable standards of the NEC, NFPA?			
8. Certification - emergency generator has been installed, tested and meets all applicable standards of the NFPA, NEC?			
9. Certification - mechanical system has been installed, tested, balanced, and approved by the engineer of record?			
10. Certification - communication system(s) has been installed, tested and meets all applicable standards of the NEC, NFPA?			
11. Are there manufacturer's operation and maintenance manuals with equipment warranties on site for all newly installed equipment or a letter from the general contractor stating that the above items will be turned over to the owner?			
12. Have all applicable pieces of equipment installed during the construction been incorporated into the existing preventive maintenance system? Or, have new maintenance policies and procedures been written to insure that said items are maintained per the manufacturers recommendations?			
13. Are there as-built drawings on site or a letter from the general contractor stating that the as-built drawings will be turned over to the owner?			
14. Are there copies of the Architect's and Engineer's final punch lists with verification that all items have been repaired or remedied?			

Referenced Publications

1. General: These ~~regulations-rules~~ include references to other codes and standards. The most current codes and standards adopted at the time of this publication are used. Later issues will normally be acceptable where requirements for function and safety are not reduced; however, editions of different dates may have portions renumbered or re-titled. Care shall be taken to ensure that appropriate sections are used.
2. Publications adopted in whole by these ~~regulations-rules~~ are as listed below:
 - a. American National Standards Institute (ANSI) Standard A17.1, "American National Standard Safety Code for Elevators, Dumbwaiters, Escalators and Moving Stairs."
 - b. American Society of Civil Engineers, (ASCE), "Minimum Design Loads for Buildings and Other Structures."
 - c. National Fire Codes - 2002.
 - d. Rules ~~and Regulations~~ Pertaining to the Management of Regulated Waste from Health Care Related Facilities, Arkansas Department of Health ~~and Human Services~~.
3. Publications adopted in part (only the sections specifically identified by these ~~regulations-rules~~ are applicable) by these ~~regulations-rules~~ are as listed below:
 - a. American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE), "Handbook of Fundamentals" and "Handbook of Applications."
 - b. American Society of Heating, Refrigerating and Air Conditioning Engineers (ASHRAE), Standard 52, "Method of Testing Air Cleaning Devices Used in General Ventilation for Removing Particulate Matter."
 - c. Illuminating Engineering Society of North America, IESNA Publication CP29, "Lighting for Health Care Facilities."
4. A partial list of other publications that are applicable to the design and construction of healthcare facilities that are not a part of these ~~regulations-rules~~ but may be enforced by other authorities having jurisdiction is provided below:
 - a. Arkansas State Fire Prevention Code Volumes I, II, and III (based on the 2000 International Building Code).
 - b. Arkansas State Mechanical Code, Arkansas Department of Health ~~and Human Services~~.

- c. Arkansas State Plumbing Code, Arkansas Department of Health ~~and Human Services~~.
 - d. Arkansas Boiler Code, Arkansas Department of Labor.
5. Publications that are not a part of these ~~regulations~~ rules but potentially helpful as reference material in the design and construction of healthcare facilities are as listed below:
- a. American Institute of Architects (AIA), "Guidelines for Design and Construction of Hospital and Health Care Facilities 2001 Edition".
 - b. American Society of Heating, Refrigeration, and Air Conditioning Engineers (ASHRAE), "HVAC Design Manual for Hospitals and Clinics".
6. Availability of Codes and Standards. Referenced publications can be ordered, if they are Government publications, from the Superintendent of Documents, U.S. Government Printing Office (GPO), Washington, DC 20402. Copies of non-government publications can be obtained at the addresses listed below.
- a. Air Conditioning and Refrigeration Institute, 1501 Wilson Boulevard, Arlington, VA 22209.
 - b. American National Standards Institute, 1430 Broadway, New York, NY 10018.
 - c. American Society of Civil Engineers, 345 East 47th Street, New York, NY 10017.
 - d. American Society for Testing and Materials, 1916 Race Street, Philadelphia, PA 19103.
 - e. American Society of Heating, Refrigerating, and Air Conditioning, 1741 Tullie Circle, NE, Atlanta GA 30329.
 - f. Arkansas Building Authority, 1515 West 7th Street, Suite 700, Little Rock, AR 72201.
 - g. Arkansas Department of Labor, 10421 West Markham, Little Rock, AR 72205.
 - h. Illuminating Engineering Society of North America (IESNA), 120 Wall Street, 17th Floor, New York, NY 10005.
 - i. National Fire Protection Association, 1 Batterymarch Park, Post Office Box 9101, Quincy, MA 02269-9101.

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- j. International Building Code Congress International, Inc., 900 Montclair Road, Birmingham, AL 35213.
7. Interpretations of Requirements. Memorandum of Understanding: Conflicts between the Arkansas Fire Prevention Code and NFPA 101 Life Safety Code are to be resolved using the Memorandum of Understanding as indicated below:
- a. The Arkansas Fire Prevention Code is the fire prevention code for the State of Arkansas.
 - b. When the Arkansas State Fire Prevention Code conflicts with the chapters of NFPA 101 Life Safety Code governing new and existing health care and ambulatory health care occupancies (Chapters 18, 19, 20, and 21), the provisions of the Life Safety Code shall govern.
 - c. Requirements found only in the Arkansas Fire Prevention Code (requirements not addressed by NFPA 101) may be provided at the option of the facility (compliance with these requirements is not mandatory).
7. Safety Improvement Plans: Nothing in these ~~regulations-rules~~ shall be construed as restrictive to a facility that chooses to do work as a part of a long-range safety improvement plan.
8. Provisions in Excess of Regulatory Requirements: Nothing in these ~~regulations-rules~~ shall be construed to prohibit a better type of building construction, an additional means of egress, or an otherwise safer condition than that specified by the minimum requirements of these ~~regulationsrules~~.
9. Equivalency: The Division may approve alternate methods, procedures, design criteria, and functional variations from these ~~regulationsrules~~, because of extraordinary circumstances, new programs, new technology, or unusual conditions when the facility can effectively demonstrate that the intent of the ~~regulations-rules~~ is met and that the variation does not reduce the safety or operational effectiveness of the facility below that required by the exact language of the ~~regulationsrules~~.

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CERTIFICATION

This will certify that the foregoing revisions to the Rules ~~and Regulations~~ for Hospice in Arkansas were adopted by the State Board of Health of Arkansas at a regular session of said Board held in Little Rock, Arkansas, on the ____ day of _____.

Jose Romero, MD, FAAP, FIDSA, FPIDS, FAAAS
Secretary of Health
Arkansas Board of Health

~~The forgoing Rules and Regulations, copy having been filed in my office, are hereby approved.~~

~~Mike Beebe~~
~~Governor~~

~~Date~~

State of Arkansas As Engrossed: H1/19/21 H2/1/21 H2/24/21 H3/1/21

93rd General Assembly

A Bill

Regular Session, 2021

HOUSE BILL 1061

By: Representatives J. Mayberry, Lundstrum, Crawford, Vaught, Bentley, Evans, Furman, Maddox, M.
McElroy, Miller, Richmond, Watson, *Brown, McKenzie, Gazaway, Payton, Penzo, Barker, Cavanaugh,*
Cloud, Dalby, Haak, Speaks

By: Senators B. Davis, K. Hammer, J. English, Irvin, A. Clark, Flippo, T. Garner

For An Act To Be Entitled

AN ACT TO CREATE THE NO PATIENT LEFT ALONE ACT;
CONCERNING VISITATION RIGHTS OF PATIENTS; TO DECLARE
AN EMERGENCY; AND FOR OTHER PURPOSES.

Subtitle

TO CREATE THE NO PATIENT LEFT ALONE ACT;
CONCERNING VISITATION RIGHTS OF PATIENTS;
AND TO DECLARE AN EMERGENCY.

BE IT ENACTED BY THE GENERAL ASSEMBLY OF THE STATE OF ARKANSAS:

*SECTION 1. Arkansas Code Title 20, Chapter 6, is amended to add an
additional subchapter to read as follows:*

Subchapter 4 – No Patient Left Alone Act

20-6-401. Title.

This subchapter shall be known and may be cited as the "No Patient Left
Alone Act".

20-6-402. Legislative findings.

The General Assembly finds that:

(1) The coronavirus 2019 (COVID-19) pandemic has caused great
uncertainty and anxiety across the state and has significantly affected the



1 medical community, including hospitals;

2 (2) Healthcare facilities have made many efforts to maintain a
3 safe environment for patients and employees and have worked to minimize, to
4 the extent possible, the risk of spread of coronavirus 2019 (COVID-19);

5 (3) There have been unintended consequences of these
6 preventative measures for patients who have not been diagnosed with
7 coronavirus 2019 (COVID-19);

8 (4) Across the state, patients who have not been diagnosed with
9 coronavirus 2019 (COVID-19) have been prohibited from having any visitors;

10 (5) As a result, many patients who were not diagnosed with
11 coronavirus 2019 (COVID-19) have been required to be alone during their
12 treatment for serious conditions, traumas, illnesses, and routine and
13 emergency surgeries;

14 (6) Some of these patients have been required to be alone for
15 the entire course of their treatment and in some cases have died alone;

16 (7) Many families have been unable to be physically present with
17 their loved ones who are being treated in a healthcare facility and have been
18 limited to electronic video communications, if any, with their loved ones;
19 and

20 (8) It is in the interest of the state and its citizens that a
21 patient be allowed at least one (1) support person who is permitted to be
22 physically present with the patient on a daily basis at reasonable times
23 throughout his or her hospitalization, visit to the office of a healthcare
24 professional, or institutionalization.

25
26 20-6-403. Definitions.

27 As used in this subchapter:

28 (1)(A) "Compassionate care visitation" means a visit with a
29 friend or family member that is necessary to meet the physical or mental
30 needs of a resident when a resident is exhibiting signs of physical or mental
31 distress, including without limitation:

32 (i) End-of-life situations;

33 (ii) Adjustment support after moving to a new
34 facility or environment;

35 (iii) Emotional support after the loss of a friend
36 or family member;

1 (iv) Physical support after eating or drinking
2 issues, including weight loss or dehydration; or

3 (v) Social support after frequent crying, distress,
4 or depression.

5 (B) "Compassionate care visitation" includes without
6 limitation:

7 (i) Clergy members;

8 (ii) Lay persons offering religious or spiritual
9 support;

10 (iii) Other persons requested by the resident for
11 the purpose of a compassionate care visit; and

12 (iv) A person providing a service requested by the
13 resident such as a hair dresser or barber;

14 (2) "Healthcare facility" means a hospital, an office of a
15 healthcare professional, a long-term care facility, or a hospice facility;

16 (3) "Healthcare professional" means a person who is licensed,
17 certified, or otherwise authorized by the laws of this state to administer
18 health care in the ordinary course of the practice of his or her profession;

19 (4) "Long-term care facility" means:

20 (A) A nursing home;

21 (B) A residential care facility;

22 (C) A post-acute head injury retraining and residential
23 facility;

24 (D) An intermediate care facility for individuals with
25 developmental disabilities;

26 (E) An assisted living facility; or

27 (F) A facility that provides long-term medical or personal
28 care;

29 (5) "Other individuals given access" means persons other than
30 patients and residents of a healthcare facility;

31 (6) "Patient with a disability" means a patient who needs
32 assistance to effectively communicate with hospital staff, make healthcare
33 decisions, or engage in activities of daily living due to a disability such
34 as:

35 (A) A physical, intellectual, behavioral, or cognitive
36 disability;

1 (B) Deafness, being hard of hearing, or other
2 communication barriers;

3 (C) Blindness;

4 (D) Autism spectrum disorder; or

5 (E) Dementia; and

6 (7) "Support person" means an individual other than a spouse or
7 legal guardian who is designated by the patient to advocate or provide
8 support for the patient.

9
10
11 20-6-404. Visitation and support for a patient with a disability.

12 (a) Upon the request of a patient with a disability, a hospital,
13 office of a healthcare professional, or hospice facility licensed in this
14 state shall allow a patient with a disability to designate at least three (3)
15 support persons and shall allow at least one (1) support person to be present
16 with the patient with a disability at all times in the emergency department
17 and during the stay of a patient with a disability in the hospital, office of
18 a healthcare professional, or hospice facility if necessary to facilitate the
19 care of the patient with a disability, including without limitation when the
20 patient with a disability:

21 (1) Has a cognitive or mental health disability that affects the
22 ability of a patient with a disability to make medical decisions or
23 understand medical advice;

24 (2) Needs assistance with activities of daily living and the
25 staff are unable to provide or are less effective at providing the
26 assistance;

27 (3) Is deaf, hard of hearing, or has other communication
28 barriers and requires the assistance of a support person to ensure effective
29 communication with staff;

30 (4) Has behavioral health needs that the support person can
31 address more effectively than the staff; or

32 (5) Is making a decision to consent to treatment or refuse
33 treatment.

34 (b) A healthcare professional or healthcare facility shall not
35 discriminate against a patient with a disability by requiring the patient
36 with a disability to:

1 (1) Execute an advance directive or a physician order for life-
2 sustaining treatment as a condition of receiving treatment or visitation; or

3 (2) Agree to a do-not-resuscitate or similar order as a
4 condition of receiving treatment or visitation.

5 (c) This section does not affect any obligation of a healthcare
6 professional or healthcare facility to:

7 (1) Provide patients with effective communication supports or
8 other reasonable accommodations in accordance with federal and state laws; or

9 (2) Make exceptions to the visitor policy of a healthcare
10 facility as a reasonable accommodation under the Americans with Disabilities
11 Act of 1990, 42 U.S.C. § 12101 et seq., as existing on January 1, 2021.
12

13 20-6-405. Hospital or office of healthcare professional visitation.

14 (a)(1) A child has the right to have a parent, legal guardian, or
15 person standing in loco parentis physically present with the child while the
16 child receives care in a hospital or an office of a healthcare professional.

17 (2) An adult patient has the right to have a spouse, support
18 person, or legal guardian physically present with the adult patient while the
19 adult receives care in a hospital or an office of a healthcare professional.

20 (3) A person with a right to be physically present under
21 subdivisions (a)(1) and (2) of this section may leave and return to the
22 hospital or office of a healthcare professional that is caring for the
23 patient.

24 (b) A hospital or an office of a healthcare professional shall not:

25 (1) Require a patient to waive the rights specified in
26 subdivisions (a)(1) and (2) of this section;

27 (2) Prevent a parent, legal guardian, or person standing in loco
28 parentis of a child receiving care in a hospital or an office of a healthcare
29 professional from having daily physical access to the child at reasonable
30 times; or

31 (3) Separate the parent, legal guardian, or person standing in
32 loco parentis of a child receiving care in a hospital or an office of a
33 healthcare professional from the child except in cases of suspected abuse or
34 threats of violence or to prevent disruption to the care of the child.

35 (c) A hospital or an office of a healthcare professional may restrict
36 access of any person to a patient:

1 (1) At the request of the patient or a law enforcement agency;
2 (2) Due to a court order;
3 (3) To prevent disruption to the care of the patient;
4 (4)(A) If the person has signs and symptoms of a transmissible
5 infection.

6 (B) However, the hospital or office of a healthcare
7 professional shall allow access through telephone, telecommunication means,
8 or other means that ensure the protection of the patient.

9 (C) The person shall follow respiratory hygiene and cough
10 etiquette as well as other infection prevention and control practices such as
11 appropriate hand hygiene;

12 (5) If the person is determined to be a danger to the patient or
13 to be contrary to the welfare of the patient; or

14 (6) According to visitation policies established under § 20-6-
15 411.

16
17 20-6-406. Hospice facility visitation.

18 A patient who is receiving hospice care or the guardian, spouse, or
19 support person of a patient who is receiving hospice care may designate
20 additional family members and friends who may be physically present with the
21 patient at reasonable times.

22
23 20-6-407. Long-term care facility visitation.

24 (a)(1) A long-term care facility shall allow compassionate care
25 visitation as needed by the resident to alleviate physical or mental
26 distress.

27 (2) Personal contact in person with a resident is permitted
28 during a compassionate care visitation if the long-term care facility
29 protocol is followed.

30 (3) A long-term care facility shall adopt a protocol for
31 personal contact in person that adheres to appropriate infection prevention
32 guidelines disseminated by the Centers for Disease Control and Prevention or
33 the Centers for Medicare and Medicaid Services.

34 (b) A long-term care facility shall work with residents, families,
35 caregivers, resident representatives, and medical providers, and may include
36 the ombudsman program under § 20-10-602 to identify the need for

1 compassionate care visitation, using a person-centered approach that takes
2 the residents requests into account.

3 (c)(1) A long-term care facility shall ensure that decisions regarding
4 end-of-life care are made by a resident with capacity or by the
5 representative of a resident without capacity, as provided in the Arkansas
6 Healthcare Decisions Act, § 20-6-101 et seq.

7 (2) Within the scope of visitation provided by this section, a
8 long-term care facility shall permit a resident making decisions regarding
9 end-of-life care to be accompanied by a family member, guardian, or support
10 person designated by the resident, unless the resident declines or requests
11 to have the discussion outside of the presence of a family member, guardian,
12 or support person.

13 (d)(1) Compassionate care visitation shall continue even if the
14 infection rate in the county in which the long-term care facility is located
15 is high.

16 (2) However, a long-term care facility shall identify one (1) or
17 more ways to allow a compassionate care visitation, including personal
18 contact, that minimize the risk of infection to the resident and other
19 residents in the long-term care facility.

20 (3)(A) In a long-term care facility with no new onset of
21 coronavirus 2019 (COVID-19) in the last fourteen (14) days and in counties
22 with coronavirus 2019 (COVID-19) positivity rates that are less than ten
23 percent (10%), a long-term care facility shall accommodate and support indoor
24 visitation for reasons beyond compassionate care visitation.

25 (B) A long-term care facility may limit:

26 (i) The number of visitors per resident at one (1)
27 time based on the size of the building and physical space; and

28 (ii) Movement in the long-term care facility, such
29 as requiring the visitor to go directly to the resident's room or designated
30 visitation area.

31 (C) Visits for residents who share a room shall not be
32 conducted in a resident's room, unless the health status of the resident
33 prevents leaving the room

34 (e) Healthcare workers who are not employees of the long-term care
35 facility but provide direct care to a resident in the long-term care
36 facility, such as hospice workers, emergency medical services personnel,

dialysis technicians, laboratory technicians, radiology technicians, and social workers, shall be permitted into the long-term care facility if proper infection control protocols are followed.

(f) A long-term care facility that fails to facilitate compassionate care visitation without adequate justification related to clinical necessity or resident safety may be in violation of 42 C.F.R. 483.10(f)(4), as it existed on January 1, 2021.

(g) To the extent permitted by state and federal law, the appropriate state agency or licensing board shall investigate and may penalize a long-term care facility's failure to comply with this section.

20-6-408. Clergy member or lay person offering religious or spiritual support visitation.

A clergy member or lay person offering religious or spiritual support may be physically present with a patient to pray with or offer spiritual support for the patient while the patient receives care in a healthcare facility.

20-6-409. Informational materials.

(a)(1) Within thirty (30) days of the effective date of this act, the Department of Health and the Department of Human Services shall develop informational materials regarding this subchapter.

(2) The Department of Health and the Department of Human Services shall present informational materials regarding this subchapter to the:

(A) Senate Committee on Public Health, Welfare, and Labor;

(B) House Committee on Public Health, Welfare, and Labor;

and

(C) House Committee on Aging, Children and Youth, Legislative and Military Affairs.

(b) A healthcare facility shall make the informational materials regarding this subchapter accessible:

(1) Upon admission or registration; and

(2) On the website of the healthcare facility.

(c) Every sixty (60) days or upon the release of relevant federal guidelines, the Department of Health, with input from the long-term care

1 industry and the hospital industry, shall reevaluate and update the
2 directives where needed to allow for the maximum visitation possible under
3 federal guidelines.

4 (d) Information and directives produced by this state that provide
5 guidance about visitation shall take into consideration and include the
6 highest amount possible of privacy and dignity for interaction between
7 patients and visitors.

8
9 20-6-410. Complaints.

10 (a) An individual may file a complaint against a healthcare
11 professional or healthcare facility for failing to comply with this
12 subchapter with the appropriate state agency or licensing board, including
13 the Department of Health and the Department of Human Services.

14 (b) The appropriate state agency or licensing board shall investigate
15 the complaint.

16
17 20-6-411. Visitation limits or restrictions.

18 A healthcare facility may establish visitation policies that limit or
19 restrict visitation when:

20 (1) The presence of visitors would be medically or
21 therapeutically contraindicated;

22 (2) The presence of visitors would interfere with the care of or
23 rights of any patient;

24 (3) Visitors are engaging in disruptive, threatening, or violent
25 behavior toward any staff member, patient, or other visitor; or

26 (4) Visitors are noncompliant with healthcare facility policy.

27
28 20-6-412. Liability of healthcare facilities.

29 (a) Unless expressly required by federal law or regulation, a state
30 survey agency or other state agency shall not take any action against a
31 healthcare facility for:

32 (1) Giving a visitor or other individual access to a healthcare
33 facility, clinic, or other similar location under this subchapter;

34 (2) Failing to protect or otherwise ensure the safety or comfort
35 of a visitor or other individual given access to a healthcare facility,
36 clinic, or other similar location under this subchapter;

1 (3) Failing to follow the Centers for Disease Control and
2 Prevention or other national guidelines that require or recommend restricting
3 visitor access; or

4 (4) The acts or omissions of any visitor or other individual who
5 is given access to a healthcare facility, clinic, or similar location.

6 (b) This section does not apply to courts or the judicial branch.

7
8 20-6-413. Construction.

9 (a) This subchapter does not apply to:

10 (1) The Arkansas State Hospital;

11 (2) A minor who is:

12 (A) In the custody of the Division of Children and Family
13 Services; or

14 (B) A suspected victim in a pending maltreatment
15 investigation;

16 (3) An individual who is in the custody of the Department of
17 Corrections; or

18 (4) An individual who is attending a preventive healthcare
19 office visit during which evidence-based guidelines for preventive care
20 recommend a confidential visit component for youth, as mutually agreed to by
21 the patient and his or her physician.

22 (b) This subchapter does not:

23 (1) Affect the rights of a legal guardian or holder of a power
24 of attorney; or

25 (2) Waive or change the long-term care facility residents'
26 rights under § 20-10-1204.

27 (c) The requirements under this subchapter shall be established as a
28 minimum for visitation in a healthcare facility but does not limit visitation
29 at a healthcare facility to only visitation outlined in this subchapter.

30 (d) The rights specified in this subchapter shall not be terminated,
31 suspended, or waived by:

32 (1) A healthcare facility;

33 (2) The Department of Health;

34 (3) The State Board of Health;

35 (4) The Department of Human Services; or

36 (5) The Governor upon declaring a disaster emergency under the

1 Arkansas Emergency Services Act of 1973, § 12-75-101 et seq., or ordering the
2 board to take action under § 20-7-110, or both.

3
4 SECTION 2. EMERGENCY CLAUSE. It is found and determined by the
5 General Assembly of the State of Arkansas that the coronavirus 2019 (COVID-
6 19) pandemic has caused great uncertainty and anxiety across the state and
7 has significantly affected the medical community, including hospitals; that
8 across the state, patients who have not been diagnosed with coronavirus 2019
9 (COVID-19) have been prohibited from having any visitors which has resulted
10 in many patients who were not diagnosed with coronavirus 2019 (COVID-19)
11 being required to be alone during their treatment for serious conditions,
12 traumas, illnesses, and routine and emergency surgeries; that some of these
13 patients have been required to be alone for the entire course of their
14 treatment and in some cases have died alone; and that this act is immediately
15 necessary to ensure that a patient is allowed at least one (1) support person
16 who is permitted to be physically present with the patient on a daily basis
17 at reasonable times throughout the patient's hospitalization or
18 institutionalization and who is permitted to accompany the patient when the
19 patient visits the office of a healthcare professional. Therefore, an
20 emergency is declared to exist, and this act being immediately necessary for
21 the preservation of the public peace, health, and safety shall become
22 effective on:

23 (1) The date of its approval by the Governor;

24 (2) If the bill is neither approved nor vetoed by the Governor,
25 the expiration of the period of time during which the Governor may veto the
26 bill; or

27 (3) If the bill is vetoed by the Governor and the veto is
28 overridden, the date the last house overrides the veto.

29
30 /s/J. Mayberry

31
32
33 **APPROVED: 3/10/21**
34
35
36