STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL CARE COMMISSION QUARTERLY MEETING
DIVISION OF HEALTH SERVICE REGULATION
809 RUGGLES DRIVE, RALEIGH NC 27603
EDGERTON BUILDING
CONFERENCE ROOM - 026A
or
VIDEO CONFERENCE (LINK: Click here to join the meeting)
or
DIAL-IN (1-984-204-1487 / Passcode: 664 691 807#)

Friday, November 5, 2021

9:00 a.m.

Agenda

I. Meeting Opens – Roll Call

II. Chairman's Comments……………………………………………………………..Dr. John Meier

III. Public Meeting Statement…………………………………………………………….Dr. John Meier

This meeting of the Medical Care Commission is open to the public but is not a public hearing. Therefore, any discussion will be limited to members of the Commission and staff unless questions are specifically directed by the Commission to someone in the audience.

IV. Ethics Statement…………………………………………………….…………………Dr. John Meier

The State Government Ethics Act requires members to act in the best interest of the public and adhere to the ethical standards and rules of conduct in the State Government Ethics Act, including the duty to continually monitor, evaluate, and manage personal, financial, and professional affairs to ensure the absence of conflicts of interest.

V. Resolution of Appreciation for the Life & Service of Albert F. Lockamy, Jr...…...……Dr. John Meier

(See Exhibit A/2)

VI. Approval of Minutes (Action Items)……………..……………………..……………..Dr. John Meier

- **August 13, 2021 (Medical Care Commission Quarterly Meeting) (See Exhibit A)**
- **September 20, 2021 (Medical Care Commission Special Rules Meeting) (See Exhibit A/1)**

- **September 24, 2021 (Executive Committee) –** To authorize the sale of bonds, the proceeds of which are to be loaned to EveryAge, formerly known as United Church Homes and Services **(See Exhibit B/1)**

- **October 21, 2021 (Executive Committee)** – To grant preliminary approval for the refunding of United Methodist Retirement Homes, Inc. bonds **(See Exhibit B/2)**

VII. Bond Program Activities……………………………….…...…………………………Geary W. Knapp

A. Quarterly Report on Bond Program **(See Exhibit B)**
B. The following notices and non-action items were received by the Executive Committee:

September 29, 2021 – UNC Health Southeastern Series 2017A, 2017B, & 2012 (Redemption)
- Par Value Outstanding: $79,920,000
- Funds provided by: Public Finance Authority

October 29, 2021 – Depaul Series 2007A (Redemption)
- Par Value Outstanding: $15,305,000
- Funds provided by: Sale of properties

VIII. Bond Projects (Action Item)

A. United Methodist Retirement Homes, Inc. (Refunding)…………...……………..Geary W. Knapp

DRAFT FINAL RESOLUTION (Final version providing final numbers will be emailed November 4th)

Note: Preliminary approval for refunding UMRH's Series 2017A & Series 2013A granted by Executive Committee on 10/21/21 (Total Par Amount = $81,175,000)

Resolution of the North Carolina Medical Care Commission Authorizing the Issuance of $[Amount] North Carolina Medical Care Commission Taxable Retirement Facilities First Mortgage Revenue Refunding Bonds (The United Methodist Retirement Homes) Series 2021B and Future Tax-Exempt Bonds to be entitled Retirement Facilities First Mortgage Revenue Refunding Bonds (The United Methodist Retirement Homes) Series 2023B

WHEREAS, the North Carolina Medical Care Commission (the "Commission") is a commission of the Department of Health and Human Services of the State of North Carolina and is authorized under Chapter 131A of the General Statutes of North Carolina, as amended (the "Act"), to borrow money and to issue in evidence thereof bonds and notes for the purpose of providing funds to pay all or any part of the cost of financing or refinancing health care facilities; and

WHEREAS, The United Methodist Retirement Homes, Incorporated (the "Corporation") is a nonprofit corporation duly incorporated and validly existing under and by virtue of the laws of the State of North Carolina and is a "non-profit agency" within the meaning of the Act; and

WHEREAS, the Corporation has made application to the Commission for a loan, which will be used for the purpose of providing funds, together with other available funds, to (1) refund all of the Commission's outstanding Retirement Facilities First Mortgage Revenue Refunding Bonds (The United Methodist Retirement Homes) Series 2013A (the "Series 2013A Bonds"); (2) refund all of the Commission's outstanding Retirement Facilities First Mortgage Revenue and Revenue Refunding Bonds (The United Methodist Retirement Homes) Series 2017A (the "Series 2017A Bonds," and together with the Series 2013A Bonds, the "Prior Bonds"); and (3) pay certain expenses incurred in connection with the issuance of the Bonds (as defined below) by the Commission (collectively, the "Plan of Finance"); and

WHEREAS, the Plan of Finance is proposed to be funded through the (i) issuance by the Commission of its Taxable Retirement Facilities First Mortgage Revenue Refunding Bonds (The United Methodist Retirement Homes) Series 2021B (the "Series 2021B Taxable Bonds") and (ii) the future sale and issuance by the Commission of a series of tax-exempt bonds entitled the North Carolina Medical Care Commission Retirement Facilities First Mortgage Revenue Refunding Bonds (The United Methodist Retirement Homes) Series 2023B (the "Future Tax-Exempt Bonds," and together with the Series 2021B Taxable Bonds, the "Bonds") in an aggregate principal amount equal to the outstanding principal amount of the Series 2021B Taxable Bonds at the time of issuance of the Future Tax-Exempt Bonds for the purpose of refunding and redeeming the Series 2021B Taxable Bonds;

WHEREAS, the Commission has determined that the public will best be served by the proposed Plan of Finance and, by a resolution adopted on October 21, 2021, has approved the issuance of the Bonds, subject to compliance by the Corporation with the conditions set forth in such resolution, and the Corporation has complied with such conditions to the satisfaction of the Commission; and

WHEREAS, there have been presented to officers and staff of the Commission draft copies of the following documents (collectively, the "Transaction Documents") relating to the issuance of the Bonds:

(a) a Contract of Purchase relating to the Series 2021B Taxable Bonds, dated the date of delivery of the Series 2021B Taxable Bonds (the "Purchase Contract"), between BB&T Community Holdings Co. (the "Purchaser"), and the Local Government Commission and approved by the Commission and the Corporation, pursuant to which the Purchaser will purchase the Series 2021B Taxable Bonds on the terms and conditions set forth therein;

(b) a Trust Agreement dated as of December 1, 2021 (the "Trust Agreement"), between the Commission and U.S. Bank National Association, as bond trustee (the "Bond Trustee");

(c) a Loan Agreement dated as of December 1, 2021 (the "Loan Agreement"), between the Commission and the Corporation;

(d) a Supplemental Indenture for Obligation No. 29, dated as of December 1, 2021 ("Supplement No. 29"), by and between the Corporation, the Foundation and U.S. Bank National Association, as master trustee (the "Master Trustee") under the Second Amended and Restated Master Trust Indenture, dated as of December 1, 2017 (the "Master Indenture"), between the Corporation, The United Methodist Retirement Homes Foundation, Inc. (the "Foundation") and the Master Trustee;

(e) Obligation No. 29, dated as of the date of issuance of the Series 2021B Taxable Bonds ("Obligation No. 29"), to be issued by the Corporation to the Commission;

(f) a Continuing Covenants Agreement dated as of December 1, 2021 (the "Covenants Agreement"), between the Corporation, the Foundation and the Purchaser;

(g) a Supplemental Indenture for Obligation No. 30 dated as of December 1, 2021 ("Supplement No. 30" and, collectively with Supplement No. 29, the "Supplements"), between the Corporation and the Master Trustee;

(h) Obligation No. 30, dated as of the date of issuance of the Series 2021B Taxable Bonds ("Obligation No. 30" and, collectively with Obligation No. 29, the "Obligations"), to be issued by the Corporation to the Purchaser;

(i) Forward Purchase Option Agreement, to be dated as of December 1, 2021 (the "Forward Purchase Agreement"), among the Local Government Commission, the Commission, the Corporation and the Purchaser, relating to the Future Tax-Exempt Bonds;

(j) Escrow Deposit Agreement, dated as of December 1, 2021 (the "2013A Escrow Agreement"), among the Commission, the Corporation and U.S. Bank National Association, as escrow agent (the "2013 Escrow Agent"), relating to the refunding of the Series 2013A Bonds;

(k) Escrow Deposit Agreement, dated as of December 1, 2021 (the "2017A Escrow Agreement," and together with the 2013A Escrow Agreement, the "Escrow Agreements"), among the Commission, the Corporation and U.S. Bank National Association, as escrow agent (the "2017A Escrow Agent"), relating to the refunding of Series 2017A Bonds; and

(l) three First Amendments dated as of December 1, 2021 to each of the three Second Amended and Restated Deeds of Trust, Assignment of Rents, Security Agreement and Fixture Filing, each dated as of December 1, 2017 (as amended, the "Corporation Deeds of Trust") and each from the Corporation to the trustee named therein for the benefit of the Master Trustee; and

WHEREAS, the Commission has determined that the Corporation is financially responsible and capable of fulfilling its obligations under the Loan Agreement, the Master Indenture, Supplement No. 29 and Obligation No. 29; and

WHEREAS, the Commission has determined that adequate provision has been made for the payment of the principal of, redemption premium, if any, and interest on the Bonds;

NOW, THEREFORE, THE NORTH CAROLINA MEDICAL CARE COMMISSION DOES HEREBY RESOLVE, as follows:

Section 1. Capitalized words and terms used in this Resolution and not defined herein shall have the same meanings in this Resolution as such words and terms are given in the Master Indenture, the Trust Agreement and the Loan Agreement.

Section 2. Pursuant to the authority granted to it by the Act, the Commission hereby authorizes (a) the issuance of the Series 2021B Taxable Bonds in the aggregate principal amount of $[Amount] and (b) the issuance of the Future Tax-Exempt Bonds in an aggregate principal amount equal to the outstanding principal amount of the Series 2021B Taxable Bonds at the time of issuance of the Future Tax-Exempt Bonds for the purpose of refunding and redeeming the Series 2021B Taxable Bonds. The

Bonds shall mature on October 1, 2047. The Bonds shall bear interest at such rates determined in accordance with the Trust Agreement and shall be subject to Sinking Fund Requirements set forth in Schedule 1 hereto. During the initial Direct Purchase Rate Period (which is fifteen years), the Bonds will bear interest as set forth in Schedule 1 hereto, subject to adjustment under certain circumstances (e.g., taxability, event of default, corporate tax rate adjustments).

The Bonds shall be issued as fully registered bonds in (i) denominations of $100,000 and any integral multiple of $5,000 in excess of $100,000 during any Direct Purchase Rate Period or Weekly Rate Period (provided, however, Bonds bearing interest at the Direct Purchase Rate may be initially issued to, and purchased by, the Purchaser in any principal amount) and (ii) denominations of $5,000 and any integral multiples thereof during any Long-Term Rate Period or Adjustable Rate Period. While bearing interest at the Weekly Rate, Long-Term Rate or Adjustable Rate, the Bonds shall be issuable in book-entry form as provided in the Trust Agreement. Interest on the Bonds shall be paid at the times and at the rates determined as specified in the Trust Agreement. Payments of principal of and interest on the Bonds shall be made to the registered owners of the Bonds in such manner as is set forth in the Trust Agreement.

Section 3. The Bonds shall be subject to (i) optional redemption, extraordinary optional redemption and mandatory redemption, (ii) during any Weekly Rate Period or Adjustable Rate Period, optional tender for purchase, and (iii) mandatory tender for purchase, all at the times, upon the terms and conditions, and at the prices set forth in the Trust Agreement.

Section 4. The proceeds of the Series 2021B Taxable Bonds shall be applied as provided in Section 2.10 of the Trust Agreement. The Commission hereby finds that the use of the proceeds of the Bonds for a loan to refund the outstanding Prior Bonds and pay certain costs of issuing the Bonds will accomplish the public purposes set forth in the Act. The Commission hereby finds that the use of the proceeds of the Future Tax-Exempt Bonds for a loan to refund the outstanding Series 2021B Taxable Bonds will accomplish the public purposes set forth in the Act.

Section 5. The forms, terms and provisions of the Trust Agreement, the Loan Agreement and the Escrow Agreements are hereby approved in all respects, and the Chairman or Vice Chairman (or any other member of the Commission designated by the Chairman) and the Secretary or any Assistant Secretary of the Commission are hereby authorized and directed to execute and deliver the Trust Agreement, the Loan Agreement and the Escrow Agreements in substantially the forms presented, together with such changes, modifications and deletions as they, with the advice of counsel, may deem necessary and appropriate, and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 6. The form, terms and provisions of the Purchase Contract and the Forward Purchase Agreement are hereby approved in all respects, and the Chairman, Vice Chairman (or any other member of the Commission designated by the Chairman), Secretary or any Assistant Secretary of the Commission are hereby authorized and directed to execute and deliver the Purchase Contract and the Forward Purchase Agreement in substantially the forms presented, together with such changes, modifications, insertions and deletions as they, with the advice of counsel, may deem necessary and appropriate, and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 7. The form of the Bonds set forth in the Trust Agreement is hereby approved in all respects, and the Chairman or Vice Chairman (or any other member of the Commission designated by the Chairman) and the Secretary or any Assistant Secretary of the Commission are hereby authorized and

directed to execute, by manual or facsimile signature as provided in such form of the Bonds, and to deliver to the Bond Trustee for authentication on behalf of the Commission, the Bonds in definitive form, which shall be in substantially the form presented, together with such changes, modifications and deletions as they, with the advice of counsel, may deem necessary, appropriate and consistent with the Trust Agreement, and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 8. The forms of the Supplements, the Obligations, the Corporation Deeds of Trust and the Covenants Agreement are hereby approved in substantially the forms presented, together with such changes, modifications, insertions and deletions as the Chairman, Vice Chairman (or any other member of the Commission designated by the Chairman), Secretary or any Assistant Secretary of the Commission, with the advice of counsel, may deem necessary and appropriate, and the execution and delivery of the Trust Agreement by the Commission shall be conclusive evidence of the approval of the documents listed in this Section by the Commission.

Section 9. The Commission hereby approves the action of the Local Government Commission authorizing the private sale of the Series 2021B Taxable Bonds and the Future Tax-Exempt Bonds to the Purchaser in accordance with the Contract of Purchase and the Forward Purchase Agreement, respectively, at the purchase price of 100% of the principal amount thereof.

Section 10. Upon their execution in the form and manner set forth in the Trust Agreement, the Series 2021B Taxable Bonds shall be deposited with the Bond Trustee for authentication, and the Bond Trustee is hereby authorized and directed to authenticate the Series 2021B Taxable Bonds and, upon the satisfaction of the conditions set forth in Section 2.10 of the Trust Agreement, the Bond Trustee shall deliver the Series 2021B Taxable Bonds to the Purchaser, against payment therefor. Upon their execution in the form and manner set forth in the Trust Agreement, the Future Tax-Exempt Bonds shall be deposited with the Bond Trustee for authentication, and the Bond Trustee is hereby authorized and directed to authenticate the Future Tax-Exempt Bonds and, upon the satisfaction of the conditions set forth in Section 2.14 of the Trust Agreement, the Bond Trustee shall deliver the Future Tax-Exempt Bonds to the Purchaser, against payment therefor.

Section 11. U.S. Bank National Association is hereby appointed as the initial Bond Trustee for the Bonds.

Section 12. If the Bonds are converted to an interest rate other than the Direct Purchase Rate, the Depository Trust Company, New York, New York is hereby appointed as the initial Securities Depository for the Bonds, with Cede & Co., a nominee thereof, being the initial Securities Depository Nominee and initial registered owner of the Bonds.

Section 13. S. Mark Payne, Secretary of the Commission, Geary W. Knapp, Assistant Secretary of the Commission, and Kathy C. Larrison and Crystal Watson-Abbott, Auditors for the Commission, are each hereby appointed a Commission Representative as that term is defined in the Loan Agreement, with full power to carry out the duties set forth therein.

Section 14. The Chairman, Vice Chairman (or any other member of the Commission designated by the Chairman), Secretary and any Assistant Secretary of the Commission are authorized and directed (without limitation except as may be expressly set forth herein) to take such action and to execute and deliver any such documents, certificates, undertakings, agreements or other instruments as they, with the

advice of counsel, may deem necessary or appropriate to effect the transactions contemplated by the Trust Agreement, the Loan Agreement, the Purchase Contract and the Forward Purchase Agreement, including, but not limited to, any amendments to the Transaction Documents required in connection with the issuance of the Future Tax-Exempt Bonds.

Section 15. This Resolution shall take effect immediately upon its passage.

Schedule 1

Sinking Fund Requirements

Due October 1	Amount	Due October 1	Amount
2022	$	2035	$
2023		2036	
2024		2037	
2025		2038	
2026		2039	
2027		2040	
2028		2041	
2029		2042	
2030		2043	
2031		2044	
2032		2045	
2033		2046	
2034		2047*	

* Maturity

Interest Rates

Taxable Interest Rate: Daily Simple SOFR plus 1.35%

Future Tax-Exempt Interest Rate: 79% of Daily Simple SOFR plus 1.0665%

Professional Fees Comparison for
The United Methodist Retirement Homes, Incorporated
Series 2021B and Future Tax-Exempt Bonds

Professional	Fees Estimated In Preliminary Approval_ Resolution	Actual Fees
Placement fee	$406,039	
Swap advisor	75,000	
Verification agent	5,000	
Corporation counsel	35,000	
Bond counsel	95,000*	
Purchaser commitment fee	101,469	
Purchaser counsel fee	50,000	
Trustee and trustee counsel fee	15,000	

*Includes estimated amount for fees in connection with the issuance of the Future Tax-Exempt Bonds in 2023 (opinions, tax due diligence, closing certificates, etc.)

IX. LeadingAge North Carolina (Presentation)…..………..……………………………..…Tom Akins

X. Old Business (Discuss Rules, fiscal note, and comments submitted) (Action Items)

A. Rules for Adoption

1. **Adult Care Home/Family Care Home Rules**……..….Nadine Pfeiffer & Megan Lamphere

Readoption of four rules following Periodic Review; Amendment of one rule (Phase 2.5)

- Rules: 10A NCAC 13F .0405, .0509, 1213; 10A NCAC 13G .0509, .1214.
  (See Exhibits C thru C/3)

XI. New Business (Discuss Rules & Fiscal Note) (Action Items)

A. Rules for Initiating Rulemaking Approval

1. **Licensing of Hospital Rules** ………………..…..…...…….Nadine Pfeiffer & Azzie Conley

Readoption of fourteen rules following Periodic Review

- Rules: 10A NCAC 13B .3801, .3903, .4103, .4104, .4106, .4305, .4603, .4801, .4805, .5102, .5105, .5406, .5408, .5411 **(See Exhibits D thru D/2)**

XII. Adoption of NCMCC Quarterly Meeting Dates for 2022 (Action Item)………………...Dr. John Meier

February 10-11, 2022
May 12-13, 2022
August 11-12, 2022
November 3-4, 2022

XIII. Refunding of Commission Bond Issues (Action Item)..……….…………..…..……..Geary W. Knapp

Recommended:

WHEREAS, the bond market is in a period of generally fluctuating interest rates, and

WHEREAS, in the event of decline of rates during the next quarter, refunding of certain projects could result in significant savings in interest expense thereby reducing the cost of health care to patients, and

WHEREAS, the Commission will not meet again until February 11, 2022 in Raleigh, North Carolina;

THEREFORE, BE IT RESOLVED; that the Commission authorize its Executive Committee to approve projects involving the refunding of existing Commission debt and amend previously approved projects to include refunding components only between this date and February 11, 2022. Refunding projects may include non-material, routine capital improvement expenditures.

XIV. Appointment of Three Executive Committee Members (Action Item)……..…………..Dr. John Meier

In accordance with 10A NCAC 13A. .0101, three members of the Executive Committee shall be appointed by a vote of the Commission of each odd year at its meeting in November. No member of the Executive Committee, except the Chairman and Vice-Chairman, shall serve more than two two-year terms in succession. The terms of the three elected/appointed Executive Committee Members will expire 12/31/2023.

XV. Meeting Adjournment

EXHIBIT A

STATE OF NORTH CAROLINA

DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL CARE COMMISSION QUARTERLY MEETING
DIVISION OF HEALTH SERVICE REGULATION
809 RUGGLES DRIVE, RALEIGH NC 27603
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Or
Via Microsoft Teams: Click here to join the meeting
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Friday, August 13, 2021

9:00 a.m.

Minutes

I. Meeting Attendance

MEMBERS PRESENT	MEMBERS ABSENT
John J. Meier, IV, M.D., Chairman Joseph D. Crocker, Vice-Chairman Kathy G. Barger Sally B. Cone Paul R.G. Cunningham, M.D. John A. Fagg, M.D. Bryant C. Foriest Linwood B. Hollowell, III Ashley H. Lloyd, D.D.S. Karen E. Moriarty Stephen T. Morton Robert E. Schaaf, M.D. Neel G. Thomas, M.D. Jeffrey S. Wilson **DIVISION OF HEALTH SERVICE REGULATION STAFF** Mark Payne, Director, DHSR/Secretary, MCC Emery Milliken, Deputy Director, DHSR Geary W. Knapp, JD, CPA, Assistant Secretary, MCC Jeff Harms, Acting Construction Chief, DHSR Bethany Burgon, Attorney General's Office Kimberly Randolph, Attorney General's Office Nadine Pfeiffer, Rules Review Manager, DHSR Tammy Sylvester, Engineering Supervisor, DHSR Construction Becky Wertz, Chief, Nursing Home Licensure Section, DHSR	Anita L. Jackson, M.D. Eileen C. Kugler, RN, MSN, MPH, FNP

Crystal Abbott, Auditor, MCC Alice Creech, Executive Assistant, MCC **OTHERS PRESENT** Tommy Brewer, Ziegler Adam Garcia, Ziegler Lee Syria, United Church Homes & Services John White, United Homes & Services Jeff Horton, NC Senior Living Association Lee Dobson, Bayada Home Care	

II. Chairman's Comment………………………………………………..………………Dr. John Meier

Dr. Meier thanked everyone for taking time out of their busy schedule to attend the quarterly meeting teleconference. He encouraged the board members to complete their ethics training and emphasized how important it is to get vaccinated to protect yourself against COVID.

III. Public Meeting Statement……………………………………………………………….Dr. John Meier

This meeting of the Medical Care Commission is open to the public but is not a public hearing. Therefore, any discussion will be limited to members of the Commission and staff unless questions are specifically directed by the Commission to someone in the audience.

IV. Ethics Statement………………………..…………………………………………………Dr. John Meier

The State Government Ethics Act requires members to act in the best interest of the public and adhere to the ethical standards and rules of conduct in the State Government Ethics Act, including the duty to continually monitor, evaluate, and manage personal, financial, and professional affairs to ensure the absence of conflicts of interest.

V. Reappointment of Members……………….……………………………………………Dr. John Meier

The following members received reappointments:

- Dr. John Meier **(See Exhibit B/6)**
- Dr. Paul Cunningham **(See Exhibit B/7)**
- Linwood Hollowell **(See Exhibit B/8)**
- Karen Moriarty **(See Exhibit B/9)**
- Jeff Wilson **(See Exhibit B/10)**

VI. Approval of Minutes (Action Items)………………………..…………………………..Dr. John Meier

- **May 14, 2021 (Medical Care Commission Quarterly Meeting) (See Exhibit A)**
- **May 20, 2021** - To approve the sale of bonds, the proceeds of which are to be loaned to the Forest at Duke, Inc. **(See Exhibit B/1)**
- **May 27, 2021** - To approve the sale of bonds, the proceeds of which are to be loaned to Lutheran Services for the Aging **(See Exhibit B/2)**

- **June 24, 2021** – Preliminary refunding approval for Aldersgate Retirement Community **(See Exhibit B/3)**
- **July 21, 2021 -** To approve the sale of bonds, the proceeds of which are to be loaned to Arbor Acres **(See Exhibit B/4)**
- **July 26, 2021 -** To approve the sale of bonds, the proceeds of which are to be loaned to Arbor Acres **(See Exhibit B/5)**

***COMMISSION ACTION*:** *A motion was made to approve the minutes by Mrs. Kathy Barger, seconded by Mr. Joe Crocker, and unanimously approved.*

VII. Bond Program Activities……………………………..………….…………………Geary W. Knapp

A. Quarterly Report on Bond Program **(See Exhibit B)**
B. The following notices and non-action items were received by the Executive Committee:

June 29, 2021 – Scotland Memorial Hospital Series 1999
- Par Value Outstanding: $4,490,000
- Funds provided by: Cash

August 2, 2021 – Rex Healthcare Series 2015B-1 & Series 2015B-2 (Conversion)
- Par Value Outstanding: $100,000,000
- New Interest Rate and New Holding Period

Technical Rule Changes:
- Adult Care Home and Family Care Home Rules – 2 rules updated repealed and recodified statute
- Emergency Medical Services and Trauma Rules – 1 rule title changed

VIII. Bond Projects (Action Item)

A. United Church Homes and Services (Newton and Thomasville)…….……..……..Geary W. Knapp

Resolution: The Commission grants preliminary approval to a transaction for United Church to provide funds, to be used, together with other available funds, to **(1) advance refund**, on a *taxable* basis, the North Carolina Medical Care Commission Series 2015A (United Church) bonds, currently outstanding in the amount of $21,530,000; and the North Carolina Medical Care Commission Series 2017C (United Church) bonds, currently outstanding in the amount of $30,285,000; **(2) enter a forward purchase agreement** that allows the exchange of the taxable refunding bonds for *tax-exempt* bonds within 90 days of the corresponding call date (2022, 2023, & 2024) of the taxable bonds; **(3) current refund** the North Carolina Medical Care Commission Series 2017A (United Church) bonds, currently outstanding in the amount of $10,300,000; and the North Carolina Medical Care Commission Series 2017B (United Church) bonds, currently outstanding in the amount of $9,490,000; and **(4) fund routine capital improvements** at Piedmont Crossings and Abernathy Laurels. The proposed transaction in its entirety will result in an estimated NPV savings of $4,928,354 and restructure debt to minimize exposure to interest rate risk. The proposed transaction is in accordance with an application received as follows:

ESTIMATED SOURCES OF FUNDS

Principal amount of bonds to be issued	$84,295,000
Total Sources of Funds	**$84,295,000**

ESTIMATED USES OF FUNDS

Use	Amount
Escrow Amount to refund Series 2015A & 2017C	$57,241,775
Amount to refund Series 2017A & Series 2017B	19,790,000
Capital Improvements	4,100,000
Debt Service Reserve Fund	2,000,000
Underwriter Discount/Placement Fee	510,000
Rating Agencies	49,975
Printing Costs	10,000
SWAP Advisor Fee	75,000
Real Estate	80,000
Accountant Fee	25,000
Verification Agent	6,000
Blue Sky Filing Fee	3,500
Bank Commitment Fee	60,000
Local Government Commission Fee	8,750
Trustee & Trustee Counsel Fee	20,000
Corporation Counsel	25,000
Bank Counsel	50,000
Underwriter Counsel	65,000
Bond Counsel	175,000
Total Uses	**$84,295,000**

Tentative approval is given with the understanding that the governing board of United Church accepts the following conditions:

1. The project will continue to be developed pursuant to the applicable Medical Care Commission guidelines.

2. Final financial feasibility must be determined prior to the issuance of bonds.

3. The project must, in all respects, meet requirements of G.S. § 131A (Health Care Facilities Finance Act).

4. The Executive Committee of the Commission is delegated the authority to approve the issuance of bonds for this project and may approve the issuance of such greater principal amount of the loan as shall be necessary to finance the project; provided, however, that the amount set forth above shall not be increased by more than ten percent (10%).

5. The bonds or notes shall be sold in such a manner and upon such terms and conditions as will, in the sole judgment of the Executive Committee of the Commission, result in the lowest cost to the facility and its residents.

6. If public approval of the bonds is required for the purpose of Section 147(f) of the Internal Revenue Code of 1986, as amended ("Section 147(f)"), this tentative approval shall constitute the recommendation of the Commission that the Governor of the State of North Carolina (the "Governor") approve the issuance of such bonds, subject to the satisfaction of the requirements of

Section 147(f) concerning the holding of a public hearing prior to the submission of such recommendation to the Governor.

7. The borrower will comply with the Commission's Resolution: Community Benefits/Charity Care Agreement and Program Description for CCRCs as adopted.

8. The borrower will furnish, prior to the sale of or issuance of the bonds or notes or execution of the leases, evidence that it is in compliance with the covenants of all of its outstanding Medical Care Commission debt.

Based on information furnished by applicant, the project is

1.	Financially feasible	✓ Yes	______ No	______ N/A
2.	Construction and related costs are reasonable	______ Yes	______ No	✓ N/A

***See Exhibit D for Compliance Information and Selected Application Information**

COMMISSION ACTION: *A motion for preliminary approval of the project was made by Mr. Bryant Foriest, seconded by Mr. Joe Crocker, and approved with the recusal of Dr. John Fagg.*

IX. Old Business (Discuss rules, fiscal note, and comments submitted)

A. Rules for Adoption **(Action Items)**

1. Hospice Licensing Construction Rules ………………….…..……….Nadine Pfeiffer & Jeff Harms

Readoption of 13 rules following Periodic Review & 3 rule amendments (Total 16 rules)

- Rules: 10A NCAC 13K .1109, .1112 - .1116, .1201, and .1204 - .1212
  (See Exhibits C thru C/3)

COMMISSION ACTION: *A motion was made to approve the Hospice Licensing Rules by Dr. Paul Cunningham, seconded by Mr. Bryant Foriest, and unanimously approved.*

2. Nursing Home Licensure Rules….........................Nadine Pfeiffer, Jeff Harms & Beverly Speroff

Amendment of one rule for technical changes

- Rule: 10A NCAC 13D .2001 **(See Exhibit C/4)**

COMMISSION ACTION: *A motion was made to approve the Nursing Home Licensure Rule for technical changes by Mrs. Kathy Barger, seconded by Mr. Joe Crocker, and unanimously approved.*

X. Moment of Silence Observed – Dr. Meier expressed a need for a moment of silence to remember our Commission member Mr. Al Lockamy who passed away on June 20, 2021, and our former DHSR Director, Mr. Drexdal Pratt who passed away on August 3, 2021. We appreciate all their contributions to the Commission, and to the citizens of North Carolina.

XI. Refunding of Commission Bond Issues (Action Item)......................................Geary W. Knapp

Recommended:

WHEREAS, the bond market is in a period of generally fluctuating interest rates, and

WHEREAS, in the event of decline of rates during the next quarter, refunding of certain projects could result in significant savings in interest expense thereby reducing the cost of health care to patients, and

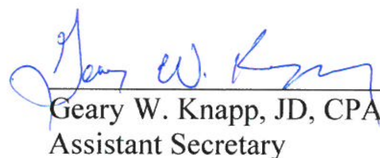
WHEREAS, the Commission will not meet again until November 5, 2021 in Raleigh, North Carolina;

THEREFORE, BE IT RESOLVED; that the Commission authorize its Executive Committee to approve projects involving the refunding of existing Commission debt and amend previously approved projects to include refunding components only between this date and November 5, 2021. Refunding projects may include non-material, routine capital improvement expenditures.

COMMISSION ACTION: *A motion was made to authorize the Executive Committee to approve projects involving the refunding of existing Commission debt between this date and November 5, 2021 by Mrs. Sally Cone, seconded by Mr. Joe Crocker, and unanimously approved.*

XII. Meeting Adjournment - There being no further business the meeting was adjourned at 10:08 a.m.

Respectfully Submitted,



Geary W. Knapp, JD, CPA
Assistant Secretary

EXHIBIT A/1

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL CARE COMMISSION SPECIAL RULES TELECONFERENCE MEETING DIVISION OF HEALTH SERVICE REGULATION

809 RUGGLES DRIVE, RALEIGH NC 27603
EDGERTON BUILDING
CONFERENCE ROOM - 026A
Or
Via Microsoft Teams: Click here to join the meeting

Via Teleconference: 1-984-204-1487 / Passcode: 603 480 616#

Monday, September 20, 2021

12:00 P.M.

Minutes

I. MEETING ATTENDANCE – MCC SPECIAL RULES MEETING

MEMBERS PRESENT	MEMBERS ABSENT
John J. Meier, IV, M.D., Chairman Kathy G. Barger Sally B. Cone Paul R.G. Cunningham, M.D. Bryant C. Foriest Linwood B. Hollowell, III Anita L. Jackson, M.D. Eileen C. Kugler, RN, MSN, MPH, FNP Ashley H. Lloyd, D.D.S. Karen E. Moriarty Stephen T. Morton Robert E. Schaaf, M.D. Neel G. Thomas, M.D. Jeffrey S. Wilson **DIVISION OF HEALTH SERVICE REGULATION STAFF** Mark Payne, DHSR Director/MCC Secretary Emery Milliken, DHSR Deputy Director Geary W. Knapp, JD, CPA, Assistant Secretary, MCC Jeff Harms, Acting DHSR Construction Chief Bethany Burgon, Attorney General's Office Kimberly Randolph, Attorney General's Office Eric Hunt, Attorney General's Office Nadine Pfeiffer, Rules Review Manager, DHSR Megan Lamphere, Chief, Adult Care Licensure Section	Joseph D. Crocker, Vice-Chairman John A. Fagg, M.D.

Libby Kinsey, Assistant Chief, Adult Care Licensure Section Shalisa Reynolds, Policy Coordinator, Adult Care Licensure Section Crystal Abbott, Auditor, MCC Alice Creech, Executive Assistant, MCC **OTHERS PRESENT** Jeff Horton, North Carolina Senior Living Association Frances Messer, North Carolina Assisted Living Association	

II. Public Meeting Statement..Dr. John Meier

This meeting of the Medical Care Commission is open to the public but is not a public hearing. Therefore, any discussion will be limited to members of the Commission and staff unless questions are specifically directed by the Commission to someone in the audience.

III. Ethics Statement...Dr. John Meier

The State Government Ethics Act requires members to act in the best interest of the public and adhere to the ethical standards and rules of conduct in the State Government Ethics Act, including the duty to continually monitor, evaluate, and manage personal, financial, and professional affairs to ensure the absence of conflicts of interest.

IV. Old Business

A. Rules for Adoption (Discuss Rules)

1. Adult Care Home & Family Care Homes Rules..............Nadine Pfeiffer & Megan Lamphere

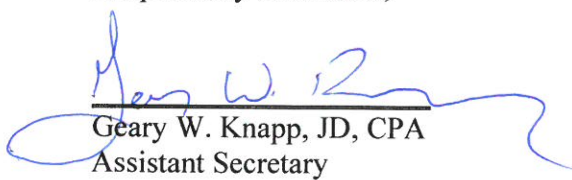
Permanent adoption of four rules for infection prevention policies and procedures, and communicable disease reporting. (Four Rules)

- Rules: 10A NCAC 13F .1801 & .1802; 10A NCAC 13G .1701 & .1702
(See Exhibits A thru A/5)

COMMISSION ACTION: *A motion was made to approve the Adult Care Home & Family Care Home Rules with minor drafting changes discussed, agreed upon, and reflected in the attached exhibits by Dr. Paul Cunningham, seconded by Mrs. Eileen Kugler, and unanimously approved.*

V. Meeting Adjournment - There being no further business, the meeting was adjourned at 12:48 p.m.

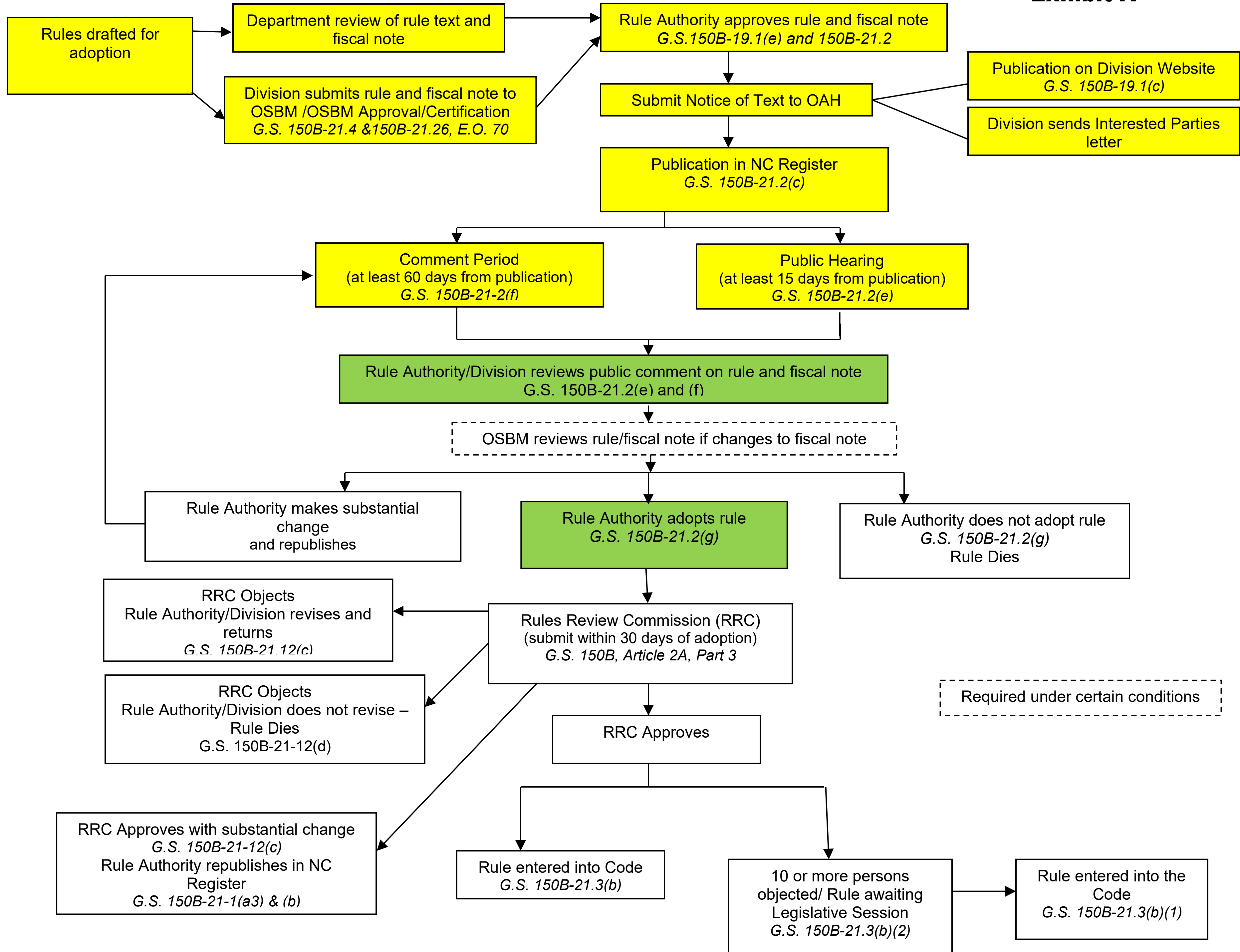
Respectfully Submitted,



Geary W. Knapp, JD, CPA
Assistant Secretary

Process for Medical Care Commission to Adopt Rule

Exhibit A



10A NCAC 13F .1801 is adopted with changes as published in 35:19 NCR 2133-2136 as follows:

SECTION .1800 - INFECTION PREVENTION AND CONTROL

10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL ~~PROGRAM~~ POLICIES AND PROCEDURES

(a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement ~~an~~ infection prevention and control ~~program (IPCP)~~ policies and procedures consistent with the federal Centers for Disease Control and Prevention (CDC) published guidelines on infection prevention and control.

~~(b)~~ The Department shall develop and approve a set of policies and procedures for infection prevention and control consistent with the federal CDC published guidelines on infection prevention and control that shall be made available on the Division of Health Service Regulation, Adult Care Licensure Section website at https://info.ncdhhs.gov/dhsr/acls/acforms.html at no cost. The facility shall ~~assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines, which are hereby incorporated by reference including subsequent amendments and editions, on infection control that are accessible at no charge online at https://www.cdc.gov/infectioncontrol, and addresses~~ either:

(1) utilize the policies and procedures for infection prevention and control approved by the Department;

(2) develop policies and procedures for infection prevention and control that are consistent with the Department approved policies and procedures; or

(3) develop policies and procedures for infection prevention and control that are based on nationally recognized standards in infection prevention and control that are consistent with the federal CDC published guidelines on infection prevention and control.

The facility's infection and control policies and procedures shall be implemented by the facility and shall address the following:

(1) Standard and transmission-based ~~precautions, for which guidance can be found on the CDC website at https://www.cdc.gov/infectioncontrol/basics,~~ precautions, including:

(A) respiratory hygiene and cough etiquette;

(B) environmental cleaning and disinfection;

(C) reprocessing and disinfection of reusable resident medical equipment;

(D) hand hygiene;

(E) accessibility and proper use of personal protective equipment (PPE); and

(F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne ~~precautions.~~ precautions;

(2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this ~~Section.~~ Section;

(3) Measures the facility should consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents and visitors for signs of illness; and use of source control as tolerated by the ~~residents.~~ residents; and

(4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease ~~outbreak:~~ outbreak.

~~(c)~~ (b) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility's ~~IPCP, related~~ infection prevention and control policies and procedures, ~~and published guidance issued by the CDC; however, if~~ and when issued, guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat that have been issued in writing by the North Carolina Department of Health and Human Services or local health ~~department, the specific guidance or directives shall be implemented by the facility.~~ department.

~~(d)~~ (c) In accordance with Rule .1211 of this Subchapter and G.S. 131D-4.4A(b)(4), the facility shall ensure all staff are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs ~~(b)(1)~~ (a)(1) through ~~(2)~~ (a)(2) of this Rule.

~~(e)~~ (d) The policies and procedures listed in Paragraph ~~(b)~~ (a) of this Rule shall be maintained in the facility and accessible to staff working at the facility.

History Note: *Authority G.S. 131D-2.16; 131D-4.4A; 143B-165;*
Emergency Adoption Eff. October 23, 2020;
Temporary Adoption Eff. December 30, ~~2020.~~ 2020;
Adopted Eff. December 1, 2021.

10A NCAC 13G .1701 is adopted with changes as published in 35:19 NCR 2133-2136 as follows:

SECTION .1700 - INFECTION PREVENTION AND CONTROL

10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL ~~PROGRAM~~ POLICIES AND PROCEDURES

(a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement ~~an~~ infection prevention and control ~~program (IPCP)~~ policies and procedures consistent with the federal Centers for Disease Control and Prevention (CDC) published guidelines on infection prevention and control.

~~(b)~~ The Department shall develop and approve a set of policies and procedures for infection prevention and control consistent with the federal CDC published guidelines on infection prevention and control that will be made available on the Division of Health Service Regulation, Adult Care Licensure Section website at https://info.ncdhhs.gov/dhsr/acls/acforms.html at no cost. The facility shall ~~assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines, which are hereby incorporated by reference including subsequent amendments and editions, on infection control that are accessible at no charge online at https://www.cdc.gov/infectioncontrol, and addresses~~ either:

(1) utilize the policies and procedures for infection prevention and control approved by the Department;

(2) develop policies and procedures for infection and prevention and control that are consistent with the Department approved policies and procedures; or

(3) develop policies and procedures for infection prevention and control that are based on nationally recognized standards in infection prevention and control that are consistent with the federal CDC published guidelines on infection prevention and control.

The facility's infection and control policies and procedures shall be implemented by the facility and shall address the following:

(1) Standard and transmission-based ~~precautions, for which guidance can be found on the CDC website at https://www.cdc.gov/infectioncontrol/basics,~~ precautions, including:

- (A) respiratory hygiene and cough etiquette;
- (B) environmental cleaning and disinfection;
- (C) reprocessing and disinfection of reusable resident medical equipment;
- (D) hand hygiene;
- (E) accessibility and proper use of personal protective equipment (PPE); and
- (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne ~~precautions.~~ precautions;

(2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1702 of this ~~Section.~~ Section;

(3) Measures the facility should consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents and visitors for signs of illness; and use of source control as tolerated by the ~~residents.~~ residents; and

(4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease ~~outbreak:~~ outbreak.

~~(c)~~ (b) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility's ~~IPCP, related~~ infection prevention and control policies and procedures, ~~and published guidance issued by the CDC; however, if~~ and when issued, guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat that have been issued in writing by the North Carolina Department of Health and Human Services or local health ~~department, the specific guidance or directives shall be implemented by the facility.~~ department.

~~(d)~~ (c) In accordance with Rule .1211 of this Subchapter and G.S. 131D-4.4A(b)(4), the facility shall ensure all staff are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs ~~(b)(1)~~ (a)(1) through ~~(2)~~ (a)(2) of this Rule.

~~(e)~~ (d) The policies and procedures listed in Paragraph ~~(b)~~ (a) of this Rule shall be maintained in the facility and accessible to staff working at the facility.

History Note: *Authority G.S. 131D-2.16; 131D-4.4A; 143B-165;*
Emergency Adoption Eff. October 23, 2020;
Temporary Adoption Eff. December 30, ~~2020.~~ 2020;
Adopted Eff. December 1, 2021.

Exhibit A/3
Fiscal Note
3/4/2021

DHSR Adult Care Licensure Section
Fiscal Impact Analysis
Permanent Rule Adoption with Substantial Economic Impact

Agency: North Carolina Medical Care Commission

Contact Persons: Nadine Pfeiffer, DHSR Rules Review Manager, (919) 855-3811
Megan Lamphere, Adult Care Licensure Section Chief, (919) 855-3784
Tichina Hamer, Director of Programs, (919) 855-3782

Impact:

Federal Government: No
State Government: Yes
Local Government: No
Private Entities: Yes
Substantial Impact: Yes

Titles of Rule Changes and N.C. Administrative Code Citation

Rule Adoption (*See proposed text of these rules in Appendix)*

10A NCAC 13G .1701	Infection Prevention and Control Program
10A NCAC 13G .1702	Reporting and Notification of a Suspected or Confirmed Communicable Disease Outbreak
10A NCAC 13F .1801	Infection Prevention and Control Program
10A NCAC 13F .1802	Reporting and Notification of a Suspected or Confirmed Communicable Disease Outbreak

Authorizing Statutes: G.S. 131D-2.16; G.S. 131D-4.4; 143B-165

Introduction:

In North Carolina, assisted living facilities are defined by law as "adult care homes." There are over 1100 licensed adult cares homes licensed by the Adult Care Licensure Section (ACLS) and approximately 39,000 licensed beds. There are two main categories of Adult Care Homes (ACHs)—family care homes and adult care homes. Family care homes (FCHs) are facilities with a licensed capacity of two to six residents. Due to the facility's licensed capacity, the number of staff working at the facility may be limited to one to two staff per shift depending upon the assessed needs of the residents. Staff may also be live-in staff.

Adult care homes are larger facilities with a licensed capacity of seven or more residents. Currently, 14% of licensed adult care homes have a licensed capacity of 100 or more residents.[1] The facility with the highest capacity has 201 beds. The majority of licensed adult care facilities

[1] (2020 Adult Care Homes data from Long Term Care Safety Initiative System)

have a capacity between 60-99 residents (47%).[1] These facilities can receive a special designation as a Special Care Unit licensed to serve residents with certain diagnoses, such as Alzheimer's disease or dementia. Forty-two percent of adult care facilities have licensed special care units.[2] Facilities are required to provide sufficient staff to provide care and supervision based on the facility's census and assessed needs of the residents. Residents admitted to adult care homes (and family care homes) must be at least 18 years old. Based on the 2020 ACLS Facility License Renewal data, 61% of the resident population was at least 65 years old. Residents ages 75 and older make up 63% of the total resident population. Almost 20% of residents are over the age of 85.

Most of the rules for both types of ACHs are the same with the primary exception of staffing and physical plant requirements since they serve the same population based on need for care and services. From this point onward in this report, the term "adult care home (ACH)" refers in general to both types of facilities—adult care homes and family care homes.

Adult care homes provide 24-hour care and services for residents who need assistance with various tasks such as personal care, medication administration, food and nutrition services, health care referral, housekeeping and laundry, social and recreational activities, and supervision for safety. These services are provided based on a resident's assessed needs. Most residents require assistance with personal care tasks such as bathing, dressing, feeding, toileting and ambulation with devices such as a wheelchair or walker. Assessed health care needs may include wound care, medication administration through injections, use of oxygen and collecting and testing fingerstick blood samples. These assessed needs, along with others referenced in 10A NCAC 13F .0903 and 10A NCAC 13G .0903, are considered "licensed health professional support (LHPS)" tasks and require a registered nurse to assess each resident who requires these tasks on a quarterly basis, provide guidance to the staff on caring for the resident, and identify any issues unable to be assessed by the facility's unlicensed staff and need to be communicated to the resident's physician.

Adult care homes employ unlicensed staff to provide personal care, administer medications and supervise residents. Regulations require staff to be at least 18 years old, have a high school diploma or general education degree (GED), and no substantiated listing on the Healthcare Personnel Registry for findings such as resident abuse, neglect and misappropriation of property. ACHs may employ individuals with no work history and no prior work experience in a healthcare setting.

Staff hired in positions that involve providing direct care to residents, such as Personal Care Aides or Medication Aides, are required by General Statutes and rules, at a minimum, to attend classroom training and have certain skills validated by a registered nurse who observes staff performing the tasks.

The purpose of licensure rules is to establish the minimum standards for adult care homes to ensure the health, safety and well-being of residents. For adult care homes in particular, licensure rules establish requirements for training unlicensed individuals who are caring for a vulnerable population with medical and cognitive impairments that place them at greater risk for abuse, neglect, exploitation, harm or even death.

[2] Data from Adult Care Homes 2020 Facility License Renewal Applications

The Need for Infection Control Rules:

Although there are several reasons why infection control rules are needed for ACHs, the primary reasons are: the unique vulnerabilities of a congregate living setting, the health conditions and age of residents, and the limitations of unlicensed staff who provide care to the residents in these settings. But most obviously, in settings where hands-on health care services are being provided to people, basic infection prevention and control practices protect people by reducing the transmission of disease and can potentially save lives.

First, ACHs are congregate living settings where residents share dining room space during meals, living room space for activities, bathrooms and share living space with another resident as roommates. Residents freely move throughout the facility to visit other residents. While residents are encouraged to interact and talk with each other during activities and dining, infectious diseases, including but not limited to, influenza, norovirus, and coronavirus, can quickly spread among residents due to the close contact with each other, as well as among roommates.

Second, residents in ACHs are at greater risk of experiencing complications and negative outcomes from exposure to various communicable diseases and bloodborne pathogens. Individuals who live in ACHs typically have physical disabilities, chronic illness, mental or behavioral health conditions, or a combination of these conditions. Residents have a range of medical and cognitive diagnoses which includes diabetes, hypertension, obesity, heart disease, stroke, chronic obstructive pulmonary disease (COPD), and dementia. In an article published by Healio, Dr. Keith Kaye reveals, "older adults become more susceptible to infections due to several factors. As people get older, it is more frequent that they have comorbid conditions, such as diabetes, renal insufficiency and arthritis. Many comorbid conditions, both the number and type of comorbid conditions, predispose people to infections".[3]

Individuals move into ACHs for assistance because of these various needs and conditions. Staff in facilities provide this personal, close contact care to many residents throughout the day. Staff are within close proximity to residents and other staff members for prolonged periods of time and touching many of the same surfaces and reusing various equipment to carry out their work. All of these factors make transmission of viruses and communicable diseases more likely to occur in this environment, and sound infection prevention and control practices are critical to maintaining the health and safety of residents and staff.

Another challenge in these congregate living settings is the difficulty in effectuating some recommended environmental controls when there is an outbreak. ACHs typically serve as a resident's home for the long term, and therefore, facilities have limited space and room availability to properly quarantine, isolate, and cohort residents if they become ill. This can make it hard for facilities to manage an outbreak once a virus has entered a facility.

[3] (Healio News, 2011) "Comorbidities, metabolic changes make elderly more susceptible to infection"

North Carolina Public Health Communicable Disease Outbreak Report Summary for 2015-2018[4] revealed 73% of reported communicable disease outbreaks were from the state's long-term care facilities, including nursing homes and adult care homes. Over this 4-year span, communicable disease repots in long-term care facilities have doubled. Of all the reports from every setting, 49% were respiratory causes with influenza being 93% of those illnesses reported; 41% were gastrointestinal causes with norovirus being 80% of those types of illnesses reported; and 10% of reports were related to other causes such as scabies.

Generally, the most common communicable disease is influenza, or "the flu." The influenza virus can be spread between residents, staff and visitors. The Centers for Disease Control and Prevention (CDC) estimates, in recent years, "that between 70 percent and 85 percent of seasonal flu-related deaths have occurred in people 65 years and older, and between 50 percent and 70 percent of seasonal flu-related hospitalizations have occurred among people in this age group".[5] The flu, for example, can worsen certain medical conditions, such as diabetes, by raising a person's blood sugar or increase the risk of serious complications.[6]

Worst Case Scenario: A Global Pandemic – COVID-19 and Its Impact on ACHs

Congregate living settings present unique challenges in infection control of communicable diseases. The coronavirus pandemic has hit long-term care residents particularly hard. "Since the start of the pandemic, 100,033 residents and staff at long-term care facilities have died from COVID-19 as of November 24, 2020."[7] In North Carolina, residential care facilities account for 10,493 case, 743 deaths, and there have been 273 outbreaks.[8] This represents over 1/10th of the total deaths in North Carolina.[9] There have been 20,978 cases, 2,280 deaths, and 303 outbreaks at nursing homes. As this data shows, highly communicable diseases can be especially deadly in congregate living situations, which is why infection control practices are an essential part of care of residents in adult and family care homes. The pandemic has highlighted and enhanced a need that previously existed which was to improve the quality of policies and training around IPC.

COVID-19 represents a worst-case scenario for assisted living settings and the impact of a communicable disease. COVID-19, is a new coronavirus that "spreads through respiratory droplets or small particles, such as those in aerosols, produced when an infected person coughs, sneezes, sings, talks, or breathes".[10] COVID-19, has killed more than 500,000 people as a result of the infection in 2020-2021, in comparison to the flu which 22,000 people

[4] Outbreak Report Summary: 2015-2018, NC DHHS Epidemiology Communicable Disease Reports. Data retrieved 1/7/2021. https://epi.dph.ncdhhs.gov/cd/figures/aggregate_outbreak_data_2015_2018.pdf
[5] (CDC, 2020) Seasonal Influenza (Flu) Who is at High Risk for Complications
[6] (WedMD.com) "6 Health Problems to Watch For"
[7] Kaiser Family Foundation, "COVID-19 Has Claimed the Lives of 100,000 Long-Term Care Residents and Staff," https://www.kff.org/policy-watch/covid-19-has-claimed-the-lives-of-100000-long-term-care-residents-and-staff/.
[8] Outbreaks and Clusters, NC DHHS COVID Dashboard. Data retrieved 1/7/2021. https://covid19.ncdhhs.gov/dashboard/ outbreaks-and-clusters
[9] NCDHHS' COVID-19 Response. Data retrieved 12/17/2020. https://covid19.ncdhhs.gov/
[10] (CDC, 2021)Frequently Asked Questions https://www.cdc.gov/coronavirus/2019-ncov/faq.html#Basics

died in 2019-2020. The flu is also a communicable disease spread through similar mode of transmission as COVID-19.

Although infectious diseases occur in both nursing homes and ACHs, unlike nursing homes, ACHs do not have the advantage of being staffed with licensed health care professionals. ACHs are not required to have a registered nurse on duty or onsite to provide clinical assessment and monitoring of residents' conditions or to oversee unlicensed personnel and implementation of infection control measures. ACHs also do not have medical directors to direct or guide facility infection prevention and control programs. In a recent survey conducted by the Division of Health Service Regulation Adult Care Licensure Section, 59% of facilities reported they do not employ a registered nurse on duty. Therefore, for the safety of residents and staff and to prevent and reduce the spread of communicable diseases in ACHs, well-defined regulations requiring comprehensive infection prevention and control policies and procedures are warranted to ensure unlicensed staff have guidelines and proper training to prevent and limit spread the spread of communicable diseases and bloodborne pathogens.

Administrators are responsible for the overall operation of the facility and often develop the policies and procedures that direct how staff are to respond to and handle incidents and accidents, emergencies and infection control. As part of improving the quality of care and services and the overall management of the facility, administrators may earn continuing education credits towards their biennial re-certification for course work related to infection control.

Facility staff have many and varied duties within ACHs, depending on the facility. They are responsible for performing multiple tasks for residents which include administering medications, meal preparation, assistance with activities of daily living, housekeeping and laundry, nutrition and food services, and ensuring safety. The lack of ongoing staff education related to infection prevention and control and the facility's policies and procedures on implementing these critical measures contributes to the increased rates of transmission of communicable diseases in this setting. Research from Walden University, studied the impact of hospital-acquired infections (HAIs) on staff and associated costs to patients and staff.[11] (Debesai, 2019) This research focused on "reprocessing medical devices to prevent HAIs".[11] The research reveals that the CDC and the Food and Drug Administration issued a health advisory that focused on ensuring adequate training for personnel involved in reprocessing medical devices to prevent HAIs", which recommended training "upon hire and at least one year after the initial hiring date".[11] This research drew a correlation between staff training and infection control measures which reduced HAIs by 70% "when employees and providers were aware of infections and had adequate training in infection prevention".[11] It was noted in the report that healthcare workers should adhere to the standards and wearing PPE.[11] Although the research was focus on HAIs, the conclusion can be drawn that providing training to adult care facility staff routinely on how to use PPE and staff adherence to wearing PPE may prevent or reduce the spread of infectious diseases.

As mentioned previously, staff working in ACHs have frequent and direct contact with residents and do not have clinical training or backgrounds. The most common qualifications that employees

[11] (Debesai, Strategies Healthcare Managers Use to Reduce, 2019)
https://scholarworks.waldenu.edu/cgi/viewcontent.cgi?article=7694&context=dissertations

of adult care homes have are completion of personal care aide training and medication aide certificates. Personal care aides must complete 80 hours of training and competency evaluation completed by a registered nurse. Personal Care aides receive basic training in infection control and universal precautions. Medication aides are unlicensed staff who administer medications to residents independently and not under the supervision of a licensed professional. N.C. Gen. Stat. § 131D-4.5B requires medication aides to complete 15 hours of training, one-time clinical skills evaluation by a registered nurse, and pass an exam. Medication aides, as part of their training, are evaluated by a registered nurse on infection control skills related to administering medications.

Lastly, based on infectious outbreak data and recent and past compliance data, there is a need for the state licensing agency to have the clear authority to enforce regulations with infection prevention and control standards and guidance for the protection of residents. Providers are required to report to public health officials per N.C. Gen. Stat. §131D-4.4B, but not required to implement written strategies that would reduce the risk of spreading infectious diseases to other residents. Current rules are vague and, as evidenced by the COVID-19 pandemic, detailed requirements are needed to promote better understanding and prevention of communicable diseases and bloodborne pathogens and implementation of safe practices to prevent harm and transmission of illness. The proposed rules ensure that basic infection prevention and control standards of care are applied consistently adult in care facilities across the state. The rules set forth clearly defined minimum requirements of IPC and provide ACLS the ability enforcement those requirements, and as a result will reduce the transmission of infectious diseases.

III. Baseline

Adult care homes have been required to comply with basic infection control standards related to bloodborne pathogens since January 1, 2012, based on N.C. Gen. Stat. § 131D-4.4A. The statute requires ACHs to develop written infection control policies consistent with CDC guidelines to prevent the spread of blood borne pathogens. The statute also requires providers to monitor the facility's compliance with IC policies and update the policies as necessary to prevent transmission. The facility is required to have a staff person on-site who is knowledgeable of the CDC infection control guidelines.

Since the adoption of current rules in 2005, facilities have been required to maintain infection control policies in accordance with 10A NCAC 13F .1211 and 13G .1211; however, the rules as written provide no specific criteria indicating what should be included in the IC policies and procedures nor measures facilities should take if there is a suspected communicable disease case or outbreak.

Although current general statutes and rules both address infection control and staff training, these requirements are limited. In 2018 and 2019, N.C. Gen. Stat. § 131D-4.4A was cited 40 times against adult care homes for reasons including medication aides using a single glucometer for multiple residents, and not following infection control policies. In the seven months prior to COVID-19 (September 2019– March 2020), 48 citations were issued to adult care homes for failure to provide training to medication aides which includes infection control training.

Infection prevention and control emergency rules were implemented effective October 23, 2020 through December 30, 2020. Since the implementation of the emergency rules, 13F .1801 and 13G

.1701, ACLS identified non-compliance in both adult care and family care homes related infection prevention and control. As a result, of the 56 facilities surveyed, adult care facilities were cited at a rate of 48.6% for non-compliance with rule 13F .1801, and family care homes were cited for non-compliance with rule 13G .1701 at a rate of 68.4%. However, these rates are based on surveys that were done primarily as a response to complaints received by the licensing agency and do not represent the overall population of adult care homes and family care homes that are expected to need to implement additional infection control procedures above those that they normally do.

Review of Proposed Rules: Infection Prevention and Control Program 10A NCAC 13F .1801 and 13G .1701

The proposed permanent rules were developed to give ACHs specific requirements to address in infection prevention and control policies and procedures and compel facilities to implement recommendations from the CDC, NCDHHS and the local health department when necessary for the health and safety of residents and staff. The rules are the minimum standards that facilities should have as part of the written IPC policies and procedures. The requirement for facilities to have IPC policies and procedures is not a new standard. Providers are currently required to comply with N.C. Gen. Stat. 131D-4.4A and 10A NCAC 13F/13G .1211 which requires infection control policies dealing specifically with bloodborne pathogens to be consistent with CDC guidelines.

It should be noted that the proposed rules apply to any communicable disease that may impact residents living at ACHs irrespective of a global pandemic. The focus of implementation of the rules will be addressed from the perspective of “normal” or “non-pandemic” events with diseases that typically impact ACHs each year, such as the influenza, norovirus and bloodborne pathogens. While COVID-19 has certainly had an incredible impact on ACHs this past year and cannot be discounted, it is not a typical or common occurrence in these facilities and will be addressed separately at the conclusion of this report.

Proposed Rule 13F .1801(a)/13G .1701(a)

The rule requires providers to establish and implement IPC programs and IC policies in accordance with CDC guidelines. It should be noted that this rule is not a new requirement. ACHs are currently required to comply with N.C. Gen. Stat. 131D-4.4A and 10A NCAC 13F/13G .1211 which require ACHs to have infection control policies and infection control policies related to bloodborne pathogens to be consistent with CDC guidelines. The proposed rule was added to provide clarity regarding the minimum requirements of the ACH’s infection control policy and present a cohesive set of rules, making it easier for providers to access and follow and improve consistency across the state.

Proposed Rule 13F .1801(b)/13G .1701(b)

Rules (b)(1) through (b)(4) provide define the areas that are to be included in a facilities’ IPC policies and procedures. These areas are the very basic foundation of infection prevention and control in a long-term care congregate living setting. The rule directs providers to assure that the policies and procedures developed are consistent with CDC guidelines. This rule provides the CDC website where providers can locate the latest information and resources, including toolkits, where are available at no cost, for provider to address the components listed in rule (b)(1)(a-f), which

requires providers, at a minimum, to address standard and transmission-based precautions. The IPC policies and procedures should specifically address the following:

- respiratory hygiene and coughing etiquette,
- environmental cleaning and disinfection,
- reprocessing and disinfection of reusable resident medical equipment;
- hand hygiene;
- accessibility and proper use of personal protective equipment (PPE);
- types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions.

The CDC website provides detailed information and some toolkits for providers to reference regarding each item required to be included in the IPC policies and procedures. These are basic, evidence-based practices employed in all health care settings to prevent the spread of illness between residents and staff. It should be noted providers are currently required to comply with U.S. Department of Labor, Occupational Safety and Health Administration (OSHA) regulations when occupational hazards are assessed by facilities. While OSHA requirements are focused on worker safety, there are some of these requirements that overlap with the proposed rules for resident safety. Also, to assist their members with implementation of this requirement, the N.C. Senior Living Association and N.C. Assisted Living Association collaborated to develop a template of policies and procedures and have provided those to their member facilities. Providers are required to have IPC policies and procedures. Any fiscal impact of updating the policies is expected to be due to ensuring that the ACH's policies discuss the minimum infection control standards. As the providers have templates and CDC information readily available, the time needed to do this should be minimal.

Rule (b)(2) requires providers to ensure policies address when and how to notify the local health department for suspected reportable communicable disease or outbreak. Providers have been required to report communicable outbreaks since 2011, when N.C. Gen. Stat. § 131D-4.4B was established. ACHs should have a procedure for staff to follow when there is a suspected or confirmed reportable communicable disease condition. Staff should be aware of what these conditions are and how and where to report. In accordance with the law, the Department established the process for ACHs to report suspected communicable disease outbreaks to local health departments by telephone within 24 hours of when the outbreak reasonably suspected to exist. There is no additional burden on facilities. ACHs will need to ensure that this process is included in their policies and procedures.

Rule (b)(3) provides guidance to ACH providers of common considerations or steps to take to mitigate and reduce the spread of a suspected or known outbreak of a communicable disease. The measures listed in the rule, including isolating infected residents, limiting or stopping group activities or communal dining, conduct screenings of staff, residents and visitors, and limit visitation are measures commonly issued in CDC guidance for long term care facilities to prevent further spread and are typically included in the recommendations given by local health departments to facilities when there is an outbreak. These measures listed in the rule can be critical to preventing

further spread when implemented in a timely manner. These standard measures are not new and are ordinarily included in CDC guidance for influenza and norovirus outbreaks in LTC settings, and are also recommended protections against COVID-19 and other diseases. This rule requires the ACHs to update current IPC policies and procedures to include these measures to be considered by staff when there is illness identified in the facility.

Rule (b)(4) requires ACHs to update current IPC policies and procedures by developing a plan to address potential staffing shortages due to an illness or an outbreak. Planning for staffing issues during an outbreak is critical as oftentimes staff also fall ill or so do their family members for whom they may have personal obligations to care for. This rule compels ACHs to coordinate staff and provide procedures for facility managers and supervisors on how to ensure there is adequate staffing to meet the needs of the residents during an outbreak. Examples may include contacting a staffing agency, using staff from a sister facility or developing a pool of on-call staff. ACHs are currently required to meet staffing requirements according to 10A NCAC 13F .0600 and 13G .0600. Therefore, the impact of this rule is updating the IPC policies and procedures to reflect staffing strategies.

Rule (c) requires ACHs to implement IPC policies and procedures when a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat. The rule is to help prevent and mitigate the spread of communicable diseases within the facility and has a direct impact on the health and safety of residents. The rule requires ACHs to follow more specific written guidance or directives when issued from the local health department or NCDHHS in response to what may be occurring in our state, in the ACHs' geographic area, or the facility itself. It is important to note that while state and local public health agencies follow guidance issued by the CDC, these agencies may also have recommendations specific to the facility, the area impacted by the infectious disease, resources available, or other factors. The rule directs facilities to follow CDC guidance, but to follow the guidance and recommendation of state and local public health officials is there is more specific guidance provided. This rule resolves any conflict between sources of guidance and requires ACHs to follow public health guidance.

Rule (d) requires ACHs to provide annual IPC training to all staff. The intent is to ensure all staff working at ACHs know and understand the facility's policies and procedures for IPC to protect residents and staff and prevent the transmission of communicable diseases and bloodborne pathogens. Per existing rule (13F/G .1211) and law (GS 131D-4.4A(b)(4)), all staff are required to be trained within 30 days of hire on the facility's policies and procedures to ensure they are able to implement these practices as they carry out their duties. The requirement for this training to be conducted annually is a new requirement and will have a fiscal impact on facilities to provide this training each year.

Rule (e) requires ACHs to ensure IPC policies and procedures are readily accessible for facility staff for reference and guidance. This is a current requirement according to 13F .1211 and 13G .1211, therefore there is no fiscal impact.

Review of Proposed Rules: 10A NCAC 13F .1802/.1702 Reporting and Notification of a Suspected or Confirmed Communicable Disease Outbreak

Rule (a) requires ACHs to report suspected or confirmed reportable communicable diseases in accordance with rules adopted by the Commission for Public Health. Since 2011, ACHs have been required to report suspected communicable disease outbreaks based on N.C. Gen. Stat. § 131D-4.4B.

Rule (b) requires ACHs to notify residents, staff and family members within 24 hours following confirmation by the local health department of a communicable disease outbreak. This is a new requirement. The intent of providing notification to residents, staff and family members within 24 hours is to mitigate the risk and spread of a confirmed communicable disease outbreak and ensure residents, staff and families are kept informed of outbreaks in the facility without sharing confidential information. Having awareness of a confirmed communicable disease outbreak prepares staff and residents for the implementation of IPC policies and procedures and keeps families abreast of possible changes in visitation.

The facility has discretion regarding how individuals are notified, such as by email, text message, or other means. If the ACH does not have an email account, letters or flyers may be considered as notification. Information to be shared may be how many residents or staff are infected, and any changes to facility policies such as visitation.

Fiscal Impact

Time Required to Update Policies and Procedures

Rules 10A NCAC 13F .1801 and 13G .1701 require ACHs to make updates to current IPC policies and procedures. The fiscal impact is based on the administrator, who is responsible for the management and operations of the facility, updating the IPC policies and procedures using the CDC resources available at no cost.

Based on a previous survey conducted by ACLS, the average administrator's salary is approximately $55,542. On average, salary and wages account for 70% of private industry worker compensation costs for employers, with benefits accounting for 30%.[12] Using this ratio, benefits would cost an additional $23,766 for a total annual cost of $79,218 and hourly cost of $38.08. Although the actual amount of time needed to update IPC policies is unknown, estimating 5 hours of research using information provided by the CDC and policy development, the cumulative cost of the administrator's time is estimated $190.40. It is also unknown how many adult care homes whose policies would need to be updated to match the proposed rules versus those whose policies would already meet the requirements. Potentially if CDC guidance changes again in the future, there would be additional time needed to update the procedures but it is unknown when this might happen and how much time would be needed. Although ACH administrators serve as administrator for multiple facilities and use the same policies, the total cost of $214,771 is based on each one administrator per facility.

Time Required to Provide Staff Training

There is a fiscal impact to provide annual training to staff as it is currently not required. The estimated cost is based on the number of staff required in accordance with the facility's licensed capacity, environmental services staff and food service for adult care homes. Medication aides

[12] Employer Costs for Employee Compensation – June 2020. BLS. https://www.bls.gov/news.release/pdf/ecec.pdf

and personal care aides' average hourly rate ranges between $10-$12 per hour or $24,480 annually.[13,14] Considering the employee's compensation and benefits for a total salary of $34,972, the cost of providing annual infection prevention and control training to direct care staff and auxiliary support staff, such as custodians and dietary staff, the estimated cost would be $18.25 per hour of training per staff. The number of staff varies as it is based on the company's operational structure and facility census. Based on minimum staffing chart and the average licensed capacity of 60 residents in facilities, the estimated cost of training 30 adult care employees and 5 family care home employees is approximately $365,380.00.

Time for ACLS Staff to Spend on Enforcement of these Rules

Review of infection prevention and control practices is currently part of the ACLS survey process. The review for compliance with infection control has been part of the survey process prior to the implementation of N.C. Gen. Stat. § 131D-4.4A. Observing infection prevention and control measures includes observing medication administration, personal care, feeding assistance and the use of PPE. Non-compliance identified requires ACLS staff to document findings in a written format. There is no change in the process for ACLS staff and no additional surveyors will need to be hired to enforce these rules. The proposed rules merely provide clarification and authority to appropriately enforce non-compliance identified. The average staff hourly rate with benefits is $44.26. The amount of time spent on enforcement includes observations, interviewing staff and residents, record reviews and documenting non-compliance. The average number of staff per survey is approximately 3 for adult care homes and 1 for family care homes. Although there is no data for the amount of time spent solely on reviewing compliance with infection control during for non-pandemic surveys, the estimated cost of enforcement is $265.56 for three hours spent conducting the survey process. Based on the number of surveys referenced in Table 2, the estimated cost is $32,132.76.

Time Required to Notify Resident or Representatives

It is anticipated that this requirement will have a minimal impact on ACHs. With technology today, communicating information to large groups of people can be simplified by using tools like email, phone messaging systems, or texting apps. The expectations of this rule is that ACHs notify residents and their responsible person, as well as their staff, when they become aware that there is a communicable disease outbreak in the facility. ACHs may send these groups an email or text providing notice of an outbreak at the facility. Based on ACLS data, 99% of licensed facilities reporting having an email address. Based on the average licensed capacity of 60 residents for facilities, adult care providers could create an email distribution list of families, residents, and/or staff for purposes of sharing information such as outbreaks or other emergencies. The estimated cost for an administrator to spend 15 minutes drafting and sending an email to comply with the rule to notify families and staff is an approximate total of $9.52 for each weekly notification.

[13] Personal care aide salary in North Carolina (careerexplorer.com)
[14] Medication Aide Salary in North Carolina (indeed.com)

Cost to Comply with CDC Guidance

There is a fiscal impact to implement Rule .1801(c) and .1701(c). The cost is based on the requirement of the facility to comply with CDC guidance. Under normal circumstances, outside of a global pandemic, most facilities' current practice is to adhere to CDC guidance and OSHA regulations, such as the cost to practice hand hygiene, cleaning and disinfecting surfaces and equipment, purchasing the necessary PPE, and paper products for food service. The cost to implement this rule comes from the increase in complying with CDC guidelines (primarily PPE) from the subset of the adult care homes who do not currently comply with CDC guidance. Implementation of these new requirements will have a positive impact on ACHs ability to carry out appropriate infection prevention and control practices. As the regulations require specific measures to be a part of a facility's policies and procedures, and for staff to be trained annually on those procedures, it serves to impress upon the facility and staff the importance of taking these precautions. In addition, the regulations set forth the expectation that "guidance" or "recommendations" from the CDC, NCDHHS or the local health department are not optional and shall be followed to the greatest extent possible. The agencies are the subject matter experts on infectious disease and best practices for preventing or stopping the spread of illnesses that can be harmful to long-term care residents. They have expertise of not only how to utilize standard and transmission-based precautions, but also can assist facilities with implementing environmental controls to ensure the daily operations of the facility are not contributing to the spread of illness. The rules also clarify procedures for when there seems to be different recommendations coming from these various agencies. While all of these agencies base their recommendations off of CDC protocols, NCDHHS and local health departments may provide direction to ACHs that is more specific and geared toward a facility's unique situation, such as the resident population, local community factors, staffing issues, facility layout, etc. Given that these rules provide more concrete and specific direction to ACHs than current regulations, it is reasonable to believe that it will be easier for ACHs to implement infection prevention and control measures, follow recommendations given by public health experts, and be better prepared when there is an outbreak of an illness.

Facilities routinely purchase PPE for staff for regular infection prevention, such as gloves, to assist residents with hands-on tasks such as eating, bathing and toileting. Providers will need to supply additional PPE required when there is an outbreak of a communicable disease that is above the baseline of normal PPE usage. There is minimal data to determine the baseline of normal PPE usage in ACHs. Due to the pandemic, NCDHHS assisted providers with purchasing PPE. Based on daily burn rate data provided for gloves, in December 2020, facilities who requested PPE reported a daily burn rate as follows: as follows:

Gloves	217 pairs
Goggles	15
N-95 masks	13
"Procedural" Masks	45
Gowns	37

However, the rate of PPE usage will be dependent upon the residents and their specific conditions and any infectious diseases that residents may have at certain times, so the rate of PPE

usage will fluctuate based on these conditions. Although the size of the adult care homes that requested PPE varied greatly (capacity of 60-120), the December 2020 data reflects the adult care homes that requested PPE had an average licensed capacity of 82 residents. Family care homes licensed capacity a maximum of 6 residents.

The chart below represents some current vendors' prices for PPE.

Type of PPE	Supplier	Average Cost/Unit
Goggles	RB Medical Supply	$5.75
Facemask	RB Medical Supply	$7.00 (box of 50)
Nonsterile, disposable patient isolation gowns	Grainger	$1.44
Nonsterile gloves	Grainger	$17.50 (box of 100)
N95 respirators	RB Medical Supply	92.50 (box of 50)

Based on these prices, the average daily cost of PPE for the average PPE burn rate above would total $207.86. However, many times goggles can be reused, so this estimate would overstate the total cost and provides a conservative estimate. This amount also reflects December 2020 usage, which was during one of the largest COVID-19 case surges and before mass vaccination in congregate living situations. In general, the overall cost of PPE would be lower without the impact of COVID-19.

Cost of Provider Violations

There is also a cost incurred by facilities as a result of violations cited by ACLS for noncompliance with implementing IPC procedures. In accordance with N.C. Gen. Stat. § 131D-34, civil penalty amounts vary based on the type of penalty and license type. The initial violation for a Type A1 for a family care home may range from $500 to $20,000, and an adult care may range from $1,000 to $20,000. Factors surrounding the violation cited will impact the penalty amount imposed. As COVID-19 became more prevalent in ACH facilities, complaints regarding infection control increased as well as the amount of non-compliance identified for failure to comply with infection control measures.

Based on ACLS data (Table 2), surveys conducted between May 2020 and October 2020, found 41% of facilities surveyed during this period were non-compliant with infection prevention and control measures. Of the facilities cited, 94% of non-compliance identified were violations. The potential cost of violations is estimated at $25,500.

(Table 2)

ACLS Survey Data – Compliance with Infection Control May 2020-October 2020	
Number of Surveys May-October 2020	**121**
Number of facilities – infection control - compliant	**71**
Number of facilities – infection control non-compliant	**50**
• Adult Care facilities	34
• Family Care facilities	16

Number of facilities cited for violations (A1, A2, UA, B, UB)	**47**
Number of facilities cited for standard deficiencies	**3**

In 2020, violations cited for infection control included lack of staff training, lack of supplies for norovirus, and failure to wear proper PPE.

Fiscal Impact of COVID-19 on Proposed Rules

Currently, during the COVID-19 global pandemic, ACHs have incurred additional costs particularly for PPE (face shields, larger gown supply, thermometers) in which ACHs have received additional financial support through the passage of appropriations and temporary increased Medicaid rates.

As a result of COVID-19 and its deadly impact, the N.G. General Assembly passed the Coronavirus Relief Act 3.0, providing $20,000,000 to licensed facilities with residents receiving Special Assistance funds to offset the increased cost of caring for residents during the pandemic. Personal Care Service rates increased for facilities with Medicaid recipients by approximately 83% from $4.10 per unit to $7.50 per unit to assist ACHs with the cost associated with providing personal care to residents.[15] Additionally, another $9,667,539 was appropriated to the N.C. Assisted Living Association and N.C. Senior Living Association to purchase COVID-19 tests for residents, staff and visitors in adult care homes.

Also, Session Law 2020-4, the 2020 COVID-19 Recovery Act, allocated $7,500,000.00 to the N.C. Senior Living Association for "(i.) the purchase of supplies and equipment necessary for life safety, health, and sanitation, such as ventilators, touch-free thermometers, gowns, disinfectant, and sanitizing wipes, and (ii) the purchase of personal protective equipment that meets the federal standards and guidelines from the Centers for Disease Control and Prevention, such as surgical and respiratory masks and gloves."

Due to the advancement of vaccines, it is likely that the cost for providers to comply with coronavirus specific precautions will be decreasing and will not extend into perpetuity.

Benefits Related to Reduction of Infectious Disease Transmission & Avoidance of Disease

Non-compliance cited due to failure or refusal of a facility to implement CDC, NCDHHS and/or local public health recommendations to prevent the spread of COVID-19, has many other associated costs as well. Some of these are: increased cost for additional PPE to the facility as the virus spreads and impacts more residents and staff; cost of staff who call out sick; cost of treatment and hospitalizations of residents and staff who contracted the virus; and the cost of resident and staff lives lost from COVID-19.

There are numerous benefits that would result from decreasing the transmission of infectious diseases to both residents and healthcare workers. As the COVID-19 pandemic represents somewhat of a worst-case scenario, the discussion of benefits also runs the gamut depending on

[15] (NC Division of Health Benefits, 2020) https://medicaid.ncdhhs.gov/blog/2020/05/06/special-bulletin-covid-19-82-expedited-hardship-advances-and-retroactive-targeted

the scale of outbreak and type of infectious disease. Decreased incidence of disease could potentially have the following benefits:

- Decrease in emergency room visits and hospitalizations for both residents and healthcare workers: According to Healthcare Finance, the average cost of a COVID-19 hospitalization for insured patients over the age of 60 was $40,208. For an uninsured patient over 60, the cost spiked to $77,323.[16] The average cost of an influenza-related inpatient hospital stay between 2006-2016 was $16,000.[17]
- Decreased occurrence of long-term impacts/reduction of risk for long-term impacts: Long-term impacts of COVID-19 infections are more likely in older people and those with many serious medical conditions. They include fatigue, shortness of breath, cough, joint pain, chest pain, muscle pain/headache, tachycardia, loss of smell or taste, memory, concentration, or sleep problems, rash, and hair loss. Heart, lung, and brain damage is also possible as are blood clots and blood vessel problems that lead to liver and kidney problems.[18] .
- Reduction of risk of death: While we cannot necessarily say that a death would be avoided, but using CDC recommended infection practices would reduce the risk of death. The central VSL estimate for 2021 according to HHS is $10.3M in 2014 dollars. This amount is not the value of saving an individual's life with certainty, but rather represents the amount that an individual would be willing to pay for a defined change in his or her own risk.
- Decrease in PPE costs: Reduced risk of transmission can lead to fewer residents with infections where staff need to use transmission precautions to determine appropriate PPE. This can decrease the overall cost of PPE if an outbreak is confined instead of spreading through the entire home.
- Decrease in sick call outs for employees: Reduced risk of transmission could lead to fewer sick day call outs from employees. This benefits the administration by leading to less time spent dealing with making sure there are enough staff to cover all of the residents. Absences may equate to approximately 5.7% of a provider's payroll in overtime for staff coverage.[19]
- A study of 161 hospitals in Pennsylvania involving 7,076 nurses who treated patients with urinary tract infections (UTIs) and surgical site infections (SSIs) focused on the impact of increasing the number of patients and patient care. The study revealed by "increasing [the] nurse workload by one patient resulted in an increase of UTIs and SSIs, resulting in 1,351 additional infections in the study population. Similarly, decreasing nurse burnout from an average of 30% to 10% 33 could result in preventing 4,160 infections, leading to cost savings of $41 million in the Pennsylvania hospitals (Cimiotti et al., 2012)".[11] "Hall, Johnson, Watt, Tsipa, and O'Connor (2016) included 46 research studies in their review and found that poor patient safety associated with moderate to high burnout and poor wellbeing of healthcare professionals. Of those 30 studies on burnout, 83.3% had a direct connection between healthcare professional burnout and poor patient safety; similarly, 88.9% of the studies on wellbeing had a direct correlation between poor wellbeing and

[16] https://www.healthcarefinancenews.com/news/average-cost-hospital-care-covid-19-ranges-51000-78000-based-age

[17] https://www.hcup-us.ahrq.gov/reports/statbriefs/sb253-Influenza-Hospitalizations-ED-Visits-2006-2016.jsp

[18] https://www.mayoclinic.org/diseases-conditions/coronavirus/in-depth/coronavirus-long-term-effects/art-20490351

[19] https://www.shrm.org/hr-today/news/hr-magazine/documents/kronos_us_executive_summary_final.pdf

poor patient safety (Hall et al., 2016).[11] Although the study takes place at a hospital setting, the impact of staff shortage or staff call outs can have similar impacts when providing care to multiple residents.

- Better quality of care for residents due to less staffing issues: A study shows that the number of care hours per resident per day delivered by NAs is an important contributor to residents' qualify of care in LTC homes.[20] If there are too many call-outs among staff due to infections or the need to quarantine after exposure, staff to resident ratios rise and quality of care may suffer.

Benefits of implementing effective infection prevention and control are reduction of staff call-outs, staff burnout and better care provided to residents. Practicing good infection prevention may reduce the number of staff getting from infected residents and co-workers. Staff infected with COVID-19 may be absent from work for several days and based on medical advice.[21] Practicing infection prevention and control reduces violations cited by ACLS for non-compliance with rules.

Alternatives Considered

The proposed permanent rules were preceded by emergency and temporary rules. The emergency and temporary infection prevention and control rules for adult care homes and family care homes included language and requirements that addressed specific COVID-19 related issues that have been prevalent in facilities during the time of the pandemic. An alternative to the current proposed permanent rules would be to keep the rules the same as the emergency and temporary rules, making no changes. However, because it is expected that the impacts of COVID-19 will continue to lessen and no longer be as great a threat to resident and staff health and safety, this language would become overly burdensome to providers and may eventually become outdated. The current proposed permanent rules are a better alternative as they lay the foundation for a basic infection prevention and control program with ACHs and help to ensure facilities are prepared for and can respond to any type of illness or transmittable disease that may impact the facility. The rules ensure that policies and procedures are based on evidence and standard practice, that staff are adequately trained, and that there is good communication between the facility and others who need to be involved.

A second alternative that could be considered in lieu of the proposed rules would be to adopt the infection prevention and control regulations for nursing homes, which are established by the federal Centers for Medicare & Medicaid Services (CMS). The CMS State Operations Manual, which governs the implementation of nursing home regulations, sets for the requirements for §483.80(a),(e),(f) and states, "*The facility must establish and maintain an IPCP (Infection Prevention and Control Program)designed to provide a safe, sanitary, and comfortable environment and to help prevent the development and transmission of communicable diseases and infections. This program must include, at a minimum, a system for preventing, identifying, reporting, investigating, and controlling infections and communicable diseases for all residents, staff, and visitors. The IPCP must follow national standards and guidelines.*" Since nursing home

[20] Boscart, V. M., Sidani, S., Poss, J., Davey, M., d'Avernas, J., Brown, P., Heckman, G., Ploeg, J., & Costa, A. P. (2018). The associations between staffing hours and quality of care indicators in long-term care. *BMC health services research*, *18*(1), 750. https://doi.org/10.1186/s12913-018-3552-5
[21] https://www.cdc.gov/coronavirus/2019-ncov/hcp/return-to-work.html

residents are typically more medically complex and susceptible to illness and rapid changes in condition, nursing homes are required to employ a myriad of clinical staff to oversee their care, including a Medical Director, Director of Nursing, and Registered Nurses. To comply with CMS regulation §483.80(b), nursing homes must also employ an "Infection Preventionist" at least part-time. The Infection Preventionist must, "*have primary professional training in nursing, medical technology, microbiology, epidemiology, or other related field; and have completed specialized training in infection prevention and control*." This staff person must also serve on the facility's quality assurance team and report out on any infection control related issues identified in the facility. Again, this alternative was not considered because ACHs do not generally care for residents with as high acuity as nursing homes, and they do not employ clinical staff that could oversee an IPCP such as Medical Director or Registered Nurses. Adopting CMS regulation for ACHs would be unduly burdensome and costly.

Lastly, another alternative would be to require the administrator of an adult care home to complete the "Infection Control in Long Term Care Facilities" course offered by the University of Chapel Hill's SPICE (Statewide Program for Infection Control and Epidemiology) program. The cost of this program is $465.00 per person. This three-day program held every spring and fall is designed to provide participants with current and practical information for the recognition and management of common infection prevention issues in non-acute care facilities, with an emphasis on long term care. Basic statistics for surveillance and antibiotic stewardship are new additions to the course. This alternative is not the most effective at this time as the course is very clinical in nature and geared toward nursing home managers and infection control nurses in those settings. The training would not be appropriate for direct care staff and ancillary staff in ACHs. SPICE does, however, offer a number of free infection prevention and control web-based trainings for all types of long-term care facilities, including adult care homes.

Conclusion

Rule Impacts	Known Costs/Benefits
Time Required to Update Policies and Procedures	$214,771 (initial cost, changes to CDC and other public health guidance would require additional time in the future)
Time Required to Provide Staff Training	$365,380 annually (based on average of 30 adult care home employees and 5 family care home employees)
Time for ACLS Staff to Spend on Enforcement of these Rules	$265.56 per survey (2 ACLS staff; three hours spent conducting the survey process)
Time Required to Notify Resident or Representatives	$9.52 for each weekly notification ($2,380 based on 2018 Aggregate Outbreak data)
Average Cost of PPE/Day for an Average ACH During an Outbreak	$207.86 (based on average requests from adult care homes that requested PPE in Dec 2020)
Cost of Provider Violations	Estimated $25,500

Benefits	$25,500 reduction in violations; unquantifiable benefits discussed above

Because of the high transmission and death rate, COVID-19 has highlighted a greater need for providers to have systems in place to mitigate the spread of communicable diseases within congregate living settings, such as adult care and family care homes. The proposed permanent rules establish minimum requirements for an infection prevention and control (IPC) plan based on sound public health practices, require on-going training of unlicensed staff, set forth reporting requirements to the local health department, and identifies for facilities when to implement more specific guidance for communicable disease control outbreaks or emerging infectious disease threats. The rules also ensure that residents, families and staff are kept informed of outbreak conditions in a facility so that they can act as necessary to protect the health and safety of themselves or their loved ones. When these IPC policies and procedures are implemented, ACHs will be able to mitigate and reduce the spread of communicable diseases, whether during a pandemic or the seasonal flu and prevent further harm and loss of life to residents and staff.

APPENDIX

10A NCAC 13F .1801 is proposed for adoption as follows:

SECTION .1800 - INFECTION PREVENTION AND CONTROL

10A NCAC 13F .1801 INFECTION PREVENTION AND CONTROL PROGRAM

(a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement an infection prevention and control program (IPCP) consistent with the federal Centers for Disease Control and Prevention (CDC) published guidelines on infection prevention and control.

(b) The facility shall assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines, which are hereby incorporated by reference including subsequent amendments and editions, on infection control that are accessible at no charge online at https://www.cdc.gov/infectioncontrol, and addresses the following:

(1) Standard and transmission-based precautions, for which guidance can be found on the CDC website at https://www.cdc.gov/infectioncontrol/basics, including:

(A) respiratory hygiene and cough etiquette;

(B) environmental cleaning and disinfection;

(C) reprocessing and disinfection of reusable resident medical equipment;

(D) hand hygiene;

(E) accessibility and proper use of personal protective equipment (PPE); and

(F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions:

(2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1802 of this Section:

(3) Measures the facility should consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents and visitors for signs of illness; and use of source control as tolerated by the residents.

(4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak:

(c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility's IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or

emerging infectious disease threat have been issued in writing by the North Carolina Department of Health and Human Services or local health department, the specific guidance or directives shall be implemented by the facility.

(d) In accordance with Rule .1211 of this Subchapter and G.S. 131D-4.4A(b)(4), the facility shall ensure all staff are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs (b)(1) through (2) of this Rule.

(e) The policies and procedures listed in Paragraph (b) of this Rule shall be maintained in the facility and accessible to staff working at the facility.

History Note: Authority G.S. 131D-2.16; 131D-4.4A; 143B-165;
Emergency Adoption Eff. October 23, 2020;
Temporary Adoption Eff. December 30, ~~2020;~~ 2020;
Adopted Eff. October 1, 2021.

10A NCAC 13F .1802 is proposed for adoption as follows:

10A NCAC 13F .1802 REPORTING AND NOTIFICATION OF A SUSPECTED OR CONFIRMED COMMUNICABLE DISEASE OUTBREAK

(a) The facility shall report suspected or confirmed communicable diseases and conditions within the time period and in the manner determined by the Commission for Public Health as specified in 10A NCAC 41A .0101 and 10A NCAC 41A .0102(a)(1) through (a)(3), which are hereby incorporated by reference, including subsequent amendments.

(b) The facility shall inform the residents and their representative(s) and staff within 24 hours following confirmation by the local health department of a communicable disease outbreak. The facility, in its notification to residents and their representative(s), shall:

(1) not disclose any personally identifiable information of the residents or staff;

(2) provide information on the measures the facility is taking to prevent or reduce the risk of transmission, including whether normal operations of the facility will change;

(3) provide weekly updates until the communicable illness within the facility has resolved, as determined by the local health department; and

(4) provide education to the resident(s) concerning measures they can take to reduce the risk of spread or transmission of infection.

History Note: *Authority G.S. 131D-2.16; 131D-4.4B; 131D-4.5; 143B-165;*
Emergency Adoption Eff. October 23, 2020;
Temporary Adoption Eff. December 30, ~~2020.~~ 2020;
Adopted Eff. October 1, 2021.

10A NCAC 13G .1701 is proposed for adoption as follows:

SECTION .1700 - INFECTION PREVENTION AND CONTROL

10A NCAC 13G .1701 INFECTION PREVENTION AND CONTROL PROGRAM

(a) In accordance with Rule .1211(a)(4) of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement an infection prevention and control program (IPCP) consistent with the federal Centers for Disease Control and Prevention (CDC) published guidelines on infection prevention and control.

(b) The facility shall assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines, which are hereby incorporated by reference including subsequent amendments and editions, on infection control that are accessible at no charge online at https://www.cdc.gov/infectioncontrol, and addresses the following:

(1) Standard and transmission-based precautions, for which guidance can be found on the CDC website at https://www.cdc.gov/infectioncontrol/basics, including:
 (A) respiratory hygiene and cough etiquette;
 (B) environmental cleaning and disinfection;
 (C) reprocessing and disinfection of reusable resident medical equipment;
 (D) hand hygiene;
 (E) accessibility and proper use of personal protective equipment (PPE); and
 (F) types of transmission-based precautions and when each type is indicated, including contact precautions, droplet precautions, and airborne precautions:

(2) When and how to report to the local health department when there is a suspected or confirmed reportable communicable disease case or condition, or communicable disease outbreak in accordance with Rule .1702 of this Section:

(3) Measures the facility should consider taking in the event of a communicable disease outbreak to prevent the spread of illness, such as isolating infected residents; limiting or stopping group activities and communal dining; limiting or restricting outside visitation to the facility; screening staff, residents and visitors for signs of illness; and use of source control as tolerated by the residents.

(4) Strategies for addressing potential staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak:

(c) When a communicable disease outbreak has been identified at the facility or there is an emerging infectious disease threat, the facility shall ensure implementation of the facility's IPCP, related policies and procedures, and published guidance issued by the CDC; however, if guidance or directives specific to the communicable disease outbreak or emerging infectious disease threat have been issued in writing by the North Carolina Department of Health and Human Services or local health department, the specific guidance or directives shall be implemented by the facility.

(d) In accordance with Rule .1211 of this Subchapter and G.S. 131D-4.4A(b)(4), the facility shall ensure all staff are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs (b)(1) through (2) of this Rule.

(e) The policies and procedures listed in Paragraph (b) of this Rule shall be maintained in the facility and accessible to staff working at the facility.

History Note: *Authority G.S. 131D-2.16; 131D-4.4A; 143B-165;*
Emergency Adoption Eff. October 23, 2020;
Temporary Adoption Eff. December 30, ~~2020;~~ 2020;
Adopted Eff. October 1, 2021.

10A NCAC 13G .1702 is proposed for adoption as follows:

10A NCAC 13G .1702 REPORTING AND NOTIFICATION OF A SUSPECTED OR CONFIRMED COMMUNICABLE DISEASE OUTBREAK

(a) The facility shall report suspected or confirmed communicable diseases and conditions within the time period and in the manner determined by the Commission for Public Health as specified in 10A NCAC 41A .0101 and 10A NCAC 41A .0102(a)(1) through (a)(3), which are hereby incorporated by reference, including subsequent amendments.

(b) The facility shall inform the residents and their representative(s) and staff within 24 hours following confirmation by the local health department of a communicable disease outbreak. The facility, in its notification to residents and their representative(s), shall:

(1) not disclose any personally identifiable information of the residents or staff;

(2) provide information on the measures the facility is taking to prevent or reduce the risk of transmission, including whether normal operations of the facility will change;

(3) provide weekly updates until the communicable illness within the facility has resolved, as determined by the local health department; and

(4) provide education to the resident(s) concerning measures they can take to reduce the risk of spread or transmission of infection.

History Note: Authority G.S. 131D-2.16; 131D-4.4B; 131D-4.5; 143B-165;
Emergency Adoption Eff. October 23, 2020;
Temporary Adoption Eff. December 30, ~~2020.~~ 2020;
Adopted Eff. October 1, 2021.

Adult Care Home & Family Care Home Rules Public Comments
10A NCAC 13F .1801 & .1802; 10A NCAC 13G .1701 & .1702
Comment Period 04/01/21 – 06/01/21

Introduction:

Three individuals submitted comments during the public comment period on the adoption rules 10A NCAC 13F .1801 & .1802; 10A NCAC 13G .1701 & .1702. Of these comments, two people made statements during the public hearing conducted on May 11, 2021. The comments were submitted by representatives from the following: N.C. Senior Living Association, Vienna Village, and the N.C. Assisted Living Association. A summary of all comments received on these rules is below:

1) Comments Received and Agency's Consideration of Comments for Rules 13F .1801 & 13G .1701 – Infection Prevention and Control Program:

Commenter	Comment Summary
1) N.C. Assisted Living Association (NCALA) *public hearing comment*	Opposition to the requirement of being in sync in writing of rules and policies being completely in sync with the CDC recommendation because they do change.
2) N.C. Senior Living Association (NCSLA) *public hearing comment*	Concern about the Centers for Disease Control, or CDC, website reference providers would be required to use for developing and implementing their infection control policies and procedures. Information and links on the CDC website constantly change. It is unreasonable to expect any provider, a FCH or small ACH with limited resources, to check the CDC website, compare and update policies and procedures, and train staff on the changes. The Commission should state what they would like required in the rule. Would like DHSR to develop a training program for providers' use similar to the bloodborne pathogen training.
3) Vienna Village *written comment*	Published guidance issued by the CDC The rule mandates using "published guidance issued by the CDC." During the COVID pandemic, much of the information coming from the CDC is in a constant state of flux and groups assisted living facilities with skilled nursing facilities. The guidance can be very confusing and hold ALFs to an unattainable level based upon their limited skilled personnel. Since the information is in a state of constant updating, it is hard to keep up with the latest. It will also create a larger burden on individually operated ALFs and family care homes. The larger corporate homes will be able to spread this constant research across a number of homes. The infection control rules adopted in 2012 were designed for blood borne pathogen violations. These standards have been long standing with minimal guidance updates from the CDC as opposed to an outbreak of a new disease such as COVID. To alleviate confusion, NC DHSR should take responsibility for providing direct guidance after reviewing CDC guidance and pass along this information directly to the operators.
4) N.C. Senior Living Association (NCSLA) *written comment* *(duplicate of public hearing comment)*	References to Centers for Disease Control or CDC website providers would be required to use for developing and implementing their infection control policies and procedures. Information and links on the CDC website constantly change. It is unreasonable to expect any provider, a FCH or small ACH with limited resources, to check the CDC website, compare and update policies and procedures, and train staff on the changes. Commission should

Commenter	Comment Summary
	state what they would like required in the rule. Would like DHSR with DPH to develop a training program for providers' use similar to the bloodborne pathogen training.

DHSR Response to Comments Above:

Concerns regarding the CDC being the sole source of infection prevention and control information

The federal Centers for Disease Control and Prevention (CDC) is the most widely used and recognized source of infection prevention and control (IPC) standards in the United States. A multitude of other state and federal agencies such as the Occupational Safety and Health Administration (OSHA) and the Centers for Medicare & Medicaid Services (CMS), as well as private organizations, use CDC standards to direct their IPC programs and procedures to ensure patients, residents, clients, staff and others are safe and protected from infectious disease. In North Carolina, adult care homes and family care homes have also been required to use the CDC as the basis for their IPC policies and procedures since the establishment of N.C.G.S. 131D-4.4A in 2011. While this statute primarily focused on preventing the spread of bloodborne pathogens, much of the requirement is identical to what is being proposed in rules 13F .1801 and 13G .1701.

Providers' concerns about the frequently changing guidance on the CDC website and recent complexity of the CDC website due to the COVID-19 pandemic is valid and appreciated. COVID-19 is/was a new and unprecedented virus that required infection prevention experts to issue guidance and recommendations frequently as more information was learned and understood about this deadly virus. But even though additional guidance was issued to combat the spread of COVID-19, basic IPC standards remained at the core of that guidance --- hand hygiene, cough and respiratory etiquette, cleaning and disinfecting high touch surfaces and equipment, and use of personal protective equipment (PPE).

All of that said, the IPC policies and procedures required in rules 13F .1801 and 13G .1701 are related to <u>basic</u> infection prevention and control practices. These standard and transmission-based precautions from the CDC have not changed in almost 20 years and are relied upon to keep residents and staff safe in their daily lives and work, as well as when there is an emerging infectious disease threat. The most common of these in the adult care home setting are influenza, norovirus, and scabies, and COVID-19 continues to be a threat in facilities as well. It is imperative that facilities have IPC policies and procedures based on established, scientific standards and that their staff are trained on how to provide care in a safe manner to prevent the spread of disease to the vulnerable population they serve and in their communities. Additionally, and as providers themselves have pointed out, adult care homes and family care homes are not required to employ medical or infection prevention professionals. Staff in these facilities are most often unlicensed personnel. This makes it all the more critical that facilities are using proven sources for information and guidance.

In response to concerns expressed in the public comments, several steps have been taken to alleviate those concerns.

- The Department is partnering with the infection prevention experts at the Statewide Program for Infection Control (SPICE) at the University of Chapel Hill to develop model/template infection prevention and control policies and procedures. These policies and procedures will be consistent with CDC guidance, cover the requirements in the proposed rule, and will be accessible and free of charge to all adult care home and family care home providers. Facility's will be expected to review these policies and procedures thoroughly and tailor them, where needed, to their particular facility.
- The language in 13F .1801(a)/13G .1701(a) was modified to include that, "<u>The facility's policies and procedures may be based on nationally recognized standards in infection prevention and control that are consistent with CDC published guidelines on infection prevention and control.</u>" This allows more flexibility for facilities to use other proven sources other than the CDC if they find the CDC website too confusing or complex. The facility must ensure, though, that the sources used for developing policies and procedures is consistent with CDC guidance.
- The language in 13F .1801(b)/13G .1701(b) was modified so that in the event of an emerging infectious disease – something happening outside of the day-to-day infection prevention protocols – the facility will be required to implement their IPC policies and procedures as well as any guidance or directive written in writing by the NC DHHS or local public health department. This represents the current practice when there is an infectious disease outbreak in an adult care facility. When there are outbreaks of influenza, norovirus, etc., facilities are required to report those cases to the local health department

who in turn provides guidance and directives to the facility on infection control measure the facility should be taking. Likewise, with COVID-19, the NC DHHS has issued guidance specific to long term care facilities (including adult care homes) that communicates changes in CDC guidance and gives directives and guidance specific to the virus. Local health departments have also done the same, often relying on the NC DHHS guidance as well.

2) Comments Received and Agency's Consideration of Fiscal Analysis Comments:

Commenter	Comment Summary
1) N.C. Assisted Living Association (NCALA) *public hearing comment*	Fiscal analysis greatly underestimates the costs associated with implementing and complying with the rules.
2) N.C. Senior Living Association (NCSLA) *public hearing comment*	Still has a problem with the fiscal note. Does not feel the fiscal note is adequate. The time required to provide staff training is estimated at $365,380 annually, based on an average of 30 ACH employees and five FCH employees. NCSLA is uncertain where these numbers came from or how they were calculated, but they are woefully underestimated. NCSLA's (with members help) analysis of associated training costs for implementing these rules determined a cost of about $1.125 million dollars for 30,000 beds, 15,000 employees and 75,000 hours for the training. The time required to notify a resident or representatives was $9.52 for each weekly notification, and it was $2380 based on a 2018 aggregate outbreak data. This figure is also grossly underestimated. During rule development, it was mentioned that providers can just send an email notification of a facility outbreak, but many people do not use email regularly, may not understand how to use it, or may not even have an email account. Most everybody has a US Mail box. An 80-bed facility notified resident families by US mail during an outbreak, and it cost them approximately $450, which included writing, stuffing the letter, envelopes and postage. For facilities to call families, a labor cost would be involved for speaking with someone, leaving messages, or returning calls, etc. Labor costs for communicating with families can often run high especially when taking time for explanations. Concerned about DHSR and OSBM's calculated cost of provider violations being estimated at $25,500. Questions if fining and penalizing facilities is the goal for improving care during an infection control outbreak during the normal course of providing care to residents. Fines and penalties money used for training is good, but facilities would already be using facility resources to pay fines, hire lawyers, etc. that could otherwise be used to improve care and not be in the resident's best interest. The rules apply to all providers, even those serving Medicaid beneficiaries. Most facilities are operating on razor thin margins and often experience cash flow problems for payroll and facility maintenance. Using the regulatory approach on providers takes away from resources used for resident care rather than a more collaborative approach with the State and counties assisting providers. This approach would require a paradigm shift; however, the time has come for more sensible and less punitive regulatory oversight of ACHs.
3) Vienna Village *written comment*	Time Required to Notify Resident or Representatives When initially in Outbreak mode, spent substantially more time on notifying residents, staff and families than 15 minutes. Approximately 3 hours was spent by administration assessing and planning actions for visitor restrictions,

Commenter	Comment Summary
	discontinuing communal dining and activities, additional cleaning and staff training. A memo was drafted explaining the outbreak and what was to be done differently to combat it. Due to Covid's contagiousness, each resident was spoken to personally about the action plan, given time for questions and reassurance. It took 3 administrators approximately 3 hours to explain this to all 70 residents (of one facility). It took approximately 1 hr. to write families an email explaining the outbreak and reassuring them. 10 of the 70 families followed up with questions that took approximately 10-15 minutes responding per inquiry. It took approximately 3 hours to develop a staff shift change email/communication with detailed information about dealing with the outbreak. This information included videos from the CDC and other websites along with detailed instructions on additional cleaning, PPE usage, etc. It took one hour to develop each weekly emails communicating with staff and families. Family emails reassured them and set up visitation options. Staff emails included additional training material on infection prevention. With restricted visitation, substantially more time was required to schedule and administer Facetime, outside and inside visits. The tasks were divided between staff, but approximately one FTE is needed to handle restricted visitation. The impact from a time and financial standpoint is significantly more than 15 minutes of an Administrator's time. It would take much longer than 24 hours to communicate with residents, staff and families which is the maximum response time that the rule mandates for notifying staff, residents and their families. <u>Wage and staffing information</u> Questions sources in fiscal analysis of the wage and staffing because it says for a 60 bed facility, the average staffing is 30, the average caregiver wage is $10-$12 per hour, and the average administrator salary is $55,000. These numbers all seem low. <u>Benefits Related to Reduction of Infectious Disease Transmission & Avoidance of Disease and Cost of Provider Violations</u> Analysis mentioned many of the benefits of reduction of infectious disease. It also stated the updated infection control rules have been in place on a temporary/emergency basis since early in the COVID pandemic. ACLS Survey Data showed that 41% of facilities inspected have been found to be in violation of these rules. If the rules are currently in place and facilities are not in compliance with the rules, unclear on how suddenly once the rules become permanent, all these facilities will suddenly become compliant, resulting in all the cost savings that the fiscal analysis states.

Commenter	Comment Summary
	Rules are a small part of what should be a larger effort to combat highly contagious diseases. The analysis shows that rules alone will not result in "cost" savings since they have failed to do so while they have been in temporary/emergency form.
4) N.C. Senior Living Association (NCSLA) *written comment, similar to public comment*	The fiscal note prepared by DHSR & OSBM greatly underestimates the costs associated with implementing and complying with the rules. Time Required to Provide Staff Training Is estimated at $365,380 annually, based on an average of 30 ACH employees and five FCH employees. NCSLA is uncertain where these numbers came from or how they were calculated. NCSLA's (with members help) analysis of associated training costs for implementing these rules determined a cost of about $1.125 million dollars for 30,000 beds, 15,000 employees and 75,000 hours for the training. (attachment with calculations attached with comment) Time Required to Notify Resident or Representatives Was $9.52 for each weekly notification, and it was $2380 based on a 2018 aggregate outbreak data. This figure is also grossly underestimated. During rule development, it was mentioned that providers can just send an email notification of a facility outbreak, but many people do not use email regularly, may not understand how to use it, or may not even have an email account. Most everybody has a US Mail box. An 80-bed facility notified resident families by US mail during the Covid outbreak, and it cost them approximately $450, which included writing, stuffing the letter, envelopes and postage. For facilities to call families, a labor cost would be involved for speaking with someone, leaving messages, or returning calls, etc. Labor costs for communicating with families can often run high especially when taking time for explanations. Cost of Provider Violations Estimated at $25,500. Questions if fining and penalizing facilities is the goal for improving care during an infection control outbreak during the normal course of providing care to residents. Fines and penalties money used for training is good, but facilities would already be using facility resources to pay fines, hire lawyers, etc. that could otherwise be used to improve care and not be in the resident's best interest. The rules apply to all providers, even those serving Medicaid beneficiaries. Most facilities are operating on razor thin margins and often experience cash flow problems for payroll and facility maintenance. Using the regulatory approach on providers takes away from resources used for resident care rather than a more collaborative approach with the State and counties assisting providers. This approach would require a paradigm shift; however, the time has come for more sensible and less punitive regulatory oversight of ACHs.

DHSR Response to Comments Above:

The fiscal note developed for the proposed permanent rules was developed in good faith with available information, including information from providers on the costs of various components of the rule. While family care homes which have 2-6 beds have many similarities, adult care homes (7 beds or more) vary widely

across the state in terms of the numbers and types of residents and the numbers and types of staff. According to the 2020 license renewal data, the smallest adult care home has a census of 3 residents (but is licensed for 31 beds) and the largest facility has a census of 130 residents. It is difficult, perhaps impossible, to draft a fiscal note that would represent every cost to every provider. The calculations included with public comments regarding staff training also seem to be inaccurate based on the agency's data.

That said, as a result of public comments several changes have been made to the rule language that will minimize costs to adult care and family care providers.

Infection Prevention & Control Policies and Procedures

- The Department is partnering with the infection prevention experts at the Statewide Program for Infection Control (SPICE) at the University of Chapel Hill to develop model/template infection prevention and control policies and procedures. These policies and procedures will be consistent with CDC guidance, cover the requirements in the proposed rule, and will be accessible and free of charge to all adult care home and family care home providers. Facilities will be expected to review these policies and procedures thoroughly and tailor them, where needed, to their particular facility. Availability of these template policies and procedures will alleviate the burden and expense to providers whether they would be developing their own policies by doing research and drafting, or if they hired a consultant to do this work. It should be noted, though, that facilities are already required in Rule (13F/13G .1211 which were adopted in 2005) have policies and procedures on infection control. Also, G.S. 131D-4.4A, established in 2011, also requires facilities to have policies and procedures which specifically cover many of the same topics as the proposed permanent rules. Facilities have had to comply with the policy and procedure component of the proposed rules since October 2020 when the emergency rules took effect. At that time, the Department reviewed and accepted model/template policies and procedures developed by the North Carolina Assisted Living Association and North Carolina Senior Living Association. Those policies and procedures meet the requirements of the rule and have been available free of charge on the internet. At this point, the impact of this part of the proposed rule would be to new providers.

Time Required to Provide Staff Training

- The new cost to providers as a result of this rule will be the cost to conduct annual training with all staff on the facility's infection prevention and control policies and procedures. Currently, rules 13F and 13G .1211 require all staff to be trained on these policies within 30 days of hire. As mentioned previously, the fiscal analysis for this rule was calculated in good faith and with information available to the Department, including information obtained from providers. Data and calculations submitted with public comments is not consistent with some of the data available to the Department, and it is not clear as to the source of the data provided. Again, the numbers and types of staff in adult care homes varies greatly across the state making it extremely difficult to assess an actual dollar figure. Additionally, some staff (medication aides and supervisors) in adult care homes and family care homes are already mandated by rule or law to have annual training on infection control and various components of the proposed rule. Because this is already required (G.S. 131D-4.5B, established in 2011), the training of these individuals should not be fully factored into the fiscal impact of the proposed rule. While it is recognized that the costs demonstrated in the fiscal note could be much higher for some facilities and much lower for others, the fiscal note was developed in good faith and with information and data available to the Department, and was approved by the Office of State Budget and Management (OSBM).

Time to Provide Notification to Residents, Families and Staff of an Outbreak

- As a result of public comments, these rules (13F .1802 and 13G .1702) were changed to allow facilities more time to provide notice to families when there is a confirmed outbreak of a communicable disease in a facility. It is, however, imperative that residents and staff are notified quickly (within 24 hours) of when an outbreak is confirmed by the local health department. Residents have a right to know this information and need to know for their safety. Staff also need to be made aware for their safety and so they can safely and adequately care for the residents without spreading further disease.

  Public comments focus on sending notifications via the U.S. Mail and the costs associated with doing so. The rule does not require that facilities send notifications via U.S. Mail. This rule was written to provide flexibility to providers in how they communicate and allows for more cost and time-efficient

ways to communicate such as through e-mail, recorded messages/phone calls, and even text or other types of "apps" that can be used for this purpose. All of these ways of communicating are much less costly than using the U.S. Mail and are already in use by many providers. Additionally, the rule is the minimum requirement. If a facility wishes to provide more information or to make individual phone calls to each family member, they may do so, but that is not required by the rule, and therefore is not the baseline for the calculation of the fiscal impact for this rule.

Fiscal Impact of Violations Cited by the Regulatory Agency

- The number of times an adult care home or family care home has been cited a violation that carries a monetary penalty for the IPC rules (Type A1, Type A2 or Unabated Type B) since the adoption of the emergency IPC rules in October 2020 has been minimal. To date out of almost 1200 facilities, DHSR has cited four Type A1 violations (serious harm or death has occurred) and 16 Type A2 violations (substantial risk of harm or death). When it is cited, it is for a facility's non-compliance that has put residents at risk or has caused serious physical harm or even death to residents. Most facilities are doing their best to comply with the temporary rules, and many are doing more for the protection of their residents and staff. These facilities have avoided complaints and regulatory citations.

  Although the Division of Health Service Regulation's (DHSR) primary role is to determine non-compliance with statutes and rules and cite facilities accordingly, the agency does much more to provide support and technical assistance to providers, including during the COVID-19 pandemic. DHSR has partnered with several other agencies to provide guidance, support and direction such as the NC Division of Public Health, local health departments across the state, and the UNC SPICE program. The NC DHHS as a whole has collaborated with provider associations to meet the needs of long-term care providers and help protect residents and staff in facilities. When a facility experiences an outbreak of COVID-19, DHSR contacts the facility to walk through a checklist of infection control measures, offers resources and support, and answers questions. DHSR has also provided several trainings throughout the years on infection prevention and control. These efforts are in addition to the work of the other above-mentioned agencies.

3) Comments Received and Agency's Consideration of General Comments:

Commenter	Comment Summary
N.C. Assisted Living Association (NCALA) *public hearing comment and duplicate written comment*	Rules would impose permanent infection control procedures on ACHs and FCHs. When rules were first proposed in early Oct. '20 during the COVID pandemic, NCALA worked with and supported the Department for developing and implementing temporary rules for the public health emergency. The rules were developed quickly due to the pandemic. Does not support these same rules becoming permanent because more time and input is needed in developing appropriate infection control rules to govern providers during times of both public health emergency and non-emergency operation periods. Supports the development and implementation of permanent rules governing infection control policies and procedures, programs, and reporting obligations for ACH and FCH, but not the adoption of the current temporary rules as permanent rules. Permanent rules should be developed outside the context of a public health emergency, with full participation of all affected stakeholders, and when they have time to offer input and have discussions about the substance of such rules. Permanent rules should be developed as quickly as possible, but sufficient time should be dedicated to the development of the rules and with participation of affected stakeholders.

DHSR Response to Comments Above:

DHSR has worked closely with stakeholders, including adult care home and family care home providers, provider associations, resident/family advocacy agencies, and other partner agencies and organizations for the past year to develop infection prevention and control rule requirements that protect residents and have the least burden on providers. Basic rules and statutes have existed for some time; however, the proposed permanent rules provide more detail and guidance to facilities on what is required. The need for more specific requirements on IPC became evident at the onset of the COVID-19 pandemic. Exacerbating issues in adult care homes and family care homes is the reality that there are not medical or infection control professionals involved in the daily operations of these facilities. They are most often staffed with unlicensed personnel who lack the clinical knowledge and expertise to develop an effective infection control program and ensure its implementation. This, coupled with the fact that residents in adult care homes have much greater acuity and more complex medical conditions than ever before, put residents' lives at stake when it comes to the spread of infectious diseases. DHSR has been responsive to the feedback received by the public and stakeholder partners as evidenced by the many revisions that have been made since the emergency rules were effective in October 2020. Providers and other stakeholders have been provided ample time and opportunity to provide feedback on proposed rules, and all feedback given has been taken into serious consideration by DHSR. The proposed permanent infection prevention and control rules are critical to helping save lives and prevent the spread of illness in facilities where there are vulnerable, medically compromised residents.

§ 131D-4.4A. Adult care home infection prevention requirements.

(a) As used in this section, "adult care home staff" means any employee of an adult care home involved in direct resident care.

(b) In order to prevent transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens, each adult care home shall do all of the following, beginning January 1, 2012:

(1) Implement a written infection control policy consistent with the federal Centers for Disease Control and Prevention guidelines on infection control that addresses at least all of the following:

a. Proper disposal of single-use equipment used to puncture skin, mucous membranes, and other tissues, and proper disinfection of reusable patient care items that are used for multiple residents.

b. Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules.

c. Accessibility of infection control devices and supplies.

d. Blood and bodily fluid precautions.

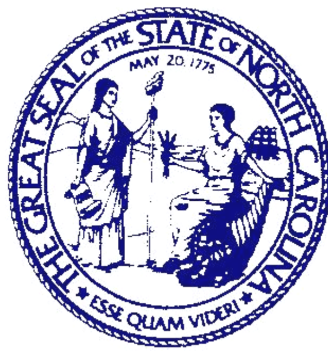
e. Procedures to be followed when adult care home staff is exposed to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV, hepatitis B, hepatitis C, or other bloodborne pathogens.

f. Procedures to prohibit adult care home staff with exudative lesions or weeping dermatitis from engaging in direct resident care that involves the potential for contact between the resident, equipment, or devices and the lesion or dermatitis until the condition resolves.

(2) Require and monitor compliance with the facility's infection control policy.

(3) Update the infection control policy as necessary to prevent the transmission of HIV, hepatitis B, hepatitis C, and other bloodborne pathogens.

(4) Designate one on-site staff member for each noncontiguous facility who is knowledgeable about the federal Centers for Disease Control and Prevention guidelines on infection control to direct the facility's infection control activities and ensure that all adult care staff is trained in the facility's infection control policy. Beginning October 1, 2013, any nonsupervisory staff member designated to direct the facility's infection control activities shall complete the infection control course developed by the Department pursuant to G.S. 131D-4.5C. (2011-99, s. 3.)



THE NORTH CAROLINA MEDICAL CARE COMMISSION RESOLUTION OF APPRECIATION

ALBERT F. LOCKAMY, JR.

WHEREAS, Albert (Al) F. Lockamy, Jr. was a member of the North Carolina Medical Care Commission from September 9, 1986 until June 20, 2021; and

WHEREAS, Mr. Lockamy served with a devotion of interest far beyond the call of duty with the highest integrity, graciousness, and efficiency; and

WHEREAS, during Mr. Lockamy's tenure, the Medical Care Commission assisted many hospitals and other health care facilities with tax exempt bond financing; and

WHEREAS, during Mr. Lockamy's tenure, significant program rules were revised and/or adopted to ensure the quality of health services to the people of North Carolina; and

WHEREAS, Mr. Lockamy devoted his time and attention to the Medical Care Commission activities in serving as a member of its Executive Committee; and

WHEREAS, Mr. Lockamy always read the Executive Committee Resolutions, and he even read Nadine Pfeiffer's rules; and

NOW, THEREFORE, BE IT RESOLVED that the North Carolina Medical Care Commission does hereby record its great appreciation for the life and service of Mr. Lockamy; and

BE IT RESOLVED, FURTHER, that this resolution be recorded in the permanent minutes of the Commission.

Resolved this the 5th day of November 5, 2021.

____
John J. Meier, IV, M.D.
Chairman

ATTEST:

____
S. Mark Payne, Secretary

NC Medical Care Commission

Quarterly Report on **Outstanding Debt** (End: 1st Quarter FYE 2022)

Program Measures	FYE 2021 Ending: 6/30/2021	FYE 2022 Ending: 9/30/2021
Outstanding Debt	**$5,458,749,746**	**$5,442,718,810**
Outstanding Series	**126**[1]	**126**[1]

Detail of Program Measures	Ending: 6/30/2021	Ending: 9/30/2021
Outstanding Debt per Hospitals and Healthcare Systems	$3,987,631,982	$3,912,920,899
Outstanding Debt per CCRCs	$1,416,747,763	$1,475,427,911
Outstanding Debt per Other Healthcare Service Providers	$54,370,000	$54,370,000
Outstanding Debt Total	**$5,458,749,746**	**$5,442,718,810**
Outstanding Series per Hospitals and Healthcare Systems	68	66
Outstanding Series per CCRCs	56	58
Outstanding Series per Other Healthcare Service Providers	2	2
Series Total	**126**	**126**
Number of Hospitals and Healthcare Systems with Outstanding Debt	14	14
Number of CCRCs with Outstanding Debt	17	17
Number of Other Healthcare Service Providers with Outstanding Debt	1	1
Facility Total	32	32

Note 1: For FYE 2022, NCMCC has closed 7 **Bond Series**. Out of the closed Bond Series: 2 were conversions, 3 were new money projects, and 2 were refundings. The Bond Series outstanding from FYE 2021 to current represents all new money projects, refundings, conversions, and redemptions.

GENERAL NOTES: Facility Totals represent a parent entity total and do not represent each individual facility owned/managed by the parent entity. CCRCs are licensed by the NC Department of Insurance. "Other Healthcare Service Providers" would include nursing homes, rehabilitation facilities, assisted living, blood donation centers, and hospice facilities. The following parent entities represent the current "other healthcare service providers" with outstanding NC MCC debt: DePaul (Assisted Living)

NC Medical Care Commission

Quarterly Report on **History** of NC MCC Finance Act Program (End: 1st Quarter FYE 2022)

Program Measures	FYE 2021 Ending: 6/30/2021	FYE 2022 Ending: 9/30/2021
Total PAR Amount of Debt Issued	**$27,586,164,692**	**$27,792,829,692**
Total Project Debt Issued (excludes refunding/conversion proceeds) [1]	**$13,433,214,540**	**$13,496,346,031**
Total Series Issued	**665**	**672**

Detail of Program Measures	Ending: 6/30/2021	Ending: 9/30/2021
PAR Amount of Debt per Hospitals and Healthcare Systems	$22,123,409,855	$22,223,409,855
PAR Amount of Debt per CCRCs	$5,088,459,607	$5,195,124,607
PAR Amount of Debt per Other Healthcare Service Providers	$374,295,230	$374,295,230
Par Amount Total	**$27,586,164,692**	**$27,792,829,692**
Project Debt per Hospitals and Healthcare Systems	$10,273,019,674	$10,273,019,674
Project Debt per CCRCs	$2,913,180,952	$2,976,312,443
Project Debt per Other Healthcare Service Providers	$247,013,915	$247,013,915
Project Debt Total	**$13,433,214,540**	**$13,496,346,031**
Series per Hospitals and Healthcare Systems	414	416
Series per CCRCs	212	217
Series per Other Healthcare Service Providers	39	39
Series Total	**665**	**672**
Number of Hospitals and Healthcare Systems issuing debt	99	99
Number of CCRCs issuing debt	40	40
Number of Other Healthcare Service Providers issuing debt	46	46
Facility Total	185	185

Note 1: Project Debt excludes bond proceeds that directly refunded prior NCMCC outstanding issues and conversion par amounts. Project Debt is an accumulation of all new project money, issuance costs (including issuance costs for refundings/conversions (if any)), and refundings of non-NCMCC debt.

GENERAL NOTES: Facility Totals represent each individual facility and do not represent parent entity totals. CCRCs are licensed by the NC Department of Insurance. "Other Healthcare Service Providers" would include nursing homes, rehabilitation facilities, assisted living, blood donation centers, and hospice facilities.

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

The North Carolina Medical Care Commission
809 Ruggles Drive
Raleigh, North Carolina

MINUTES

CALLED MEETING OF THE EXECUTIVE COMMITTEE CONFERENCE TELEPHONE MEETING ORIGINATING FROM THE COMMISSION'S OFFICE SEPTEMBER 24, 2021 11:30 A.M.

Members of the Executive Committee Present:

John J. Meier, IV, Chairman
Joseph D. Crocker, Vice-Chairman
Bryant C. Foriest
Eileen C. Kugler
Jeffrey S. Wilson

Members of the Executive Committee Absent:

Sally B. Cone
Linwood B. Hollowell, III

Members of Staff Present:

Emery E. Milliken, DHSR Deputy Director
Geary W. Knapp, JD, CPA, Assistant Secretary
Kathy C. Larrison, MCC Auditor
Crystal Watson-Abbott, MCC Auditor
Alice S. Creech, Executive Assistant

Others Present:

Lee Syria, EveryAge
John White, EveryAge
Lisa Williams, McGuire Woods, LLP
Tommy Brewer, Ziegler
Adam Garcia, Ziegler

1. **Purpose of Meeting**

To authorize the sale of bonds, the proceeds of which are to be loaned to EveryAge, formerly known as United Church.

2. **SERIES RESOLUTION AUTHORIZING SALE AND ISSUANCE OF THE NORTH CAROLINA MEDICAL CARE COMMISSION RETIREMENT FACILITIES FIRST MORTGAGE REVENUE BONDS (EVERYAGE) SERIES 2021A, TAXABLE RETIREMENT FACILITIES FIRST MORTGAGE REVENUE REFUNDING BONDS (EVERYAGE) SERIES 2021B, TAXABLE RETIREMENT FACILITIES FIRST MORTGAGE REVENUE REFUNDING BONDS (EVERYAGE) SERIES 2021C, TAXABLE RETIREMENT FACILITIES FIRST MORTGAGE REVENUE REFUNDING BONDS (EVERYAGE) SERIES 2021D AND THREE SUBSEQUENT SERIES OF FUTURE TAX-EXEMPT BONDS TO BE ENTITLED RETIREMENT FACILITIES REVENUE REFUNDING BONDS (EVERYAGE), SERIES 2021.**

EXECUTIVE COMMITTEE ACTION: *A Motion was made to approve the resolution by Mr. Bryant Foriest, seconded by Mr. Joe Crocker, and unanimously approved.*

WHEREAS, the North Carolina Medical Care Commission (the "Commission") is a commission of the Department of Health and Human Services of the State of North Carolina and is authorized under Chapter 131A of the General Statutes of North Carolina, as amended (the "Act"), to borrow money and to issue in evidence thereof bonds and notes for the purpose of providing funds to pay all or any part of the cost of financing or refinancing health care facilities;

WHEREAS, EveryAge, previously known as United Church Homes and Services (the "Corporation"), is a nonprofit corporation duly incorporated and validly existing under and by virtue of the laws of the State of North Carolina which owns and operates continuing care retirement communities located in Thomasville and Newton, North Carolina;

WHEREAS, Lake Prince Center, Inc. ("Lake Prince") is a nonprofit corporation duly incorporated and validly existing under and by virtue of the laws of the State of North Carolina which owns and operates a continuing care retirement community located in Suffolk, Virginia;

WHEREAS, the Corporation has made an application to the Commission for a loan for the purpose of providing funds, together with other available funds, to:

(i) refund all of the Medical Care Commission’s outstanding (A) Retirement Facilities First Mortgage Revenue Refunding Bonds (United Church Homes and Services), Series 2015A (the "Series 2015A Bonds"), (B) Retirement Facilities First Mortgage Revenue Bonds (United Church Homes and Services), Series 2017A (the "Series 2017A Bonds"), (C) Retirement Facilities First Mortgage Revenue Bonds (United Church Homes and Services), Series 2017B (the "Series 2017B Bonds"), and (D) Retirement Facilities First Mortgage Revenue Refunding Bonds (United Church Homes and Services), Series 2017C (the "Series 2017C Bonds" and together with the

Series 2015A Bonds, the Series 2017A Bonds, and the Series 2017B Bonds, the "Prior Bonds");

(ii) pay, or reimburse the Corporation for paying, the costs of (A)(1) the acquisition and construction of infrastructure improvements to the continuing care retirement community known as Piedmont Crossing ("Piedmont Crossing"), including, but not limited to, roofs and related structures and water and sewage facilities; and (2) the acquisition and construction of routine capital improvements for Piedmont Crossing, including, but not limited to, roof, pavement and sidewalk repairs and replacements, and (B) the acquisition and construction of routine capital improvements for the continuing care retirement community known as Abernethy Laurels, including, but not limited to, roof, pavement and sidewalk repairs and replacements;

(iii) fund a debt service reserve fund; and

(iv) pay certain expenses incurred in connection with the issuance of the Bonds (as hereinafter defined) (collectively, the "Plan of Finance");

WHEREAS, the Plan of Finance would be funded through the issuance by the Commission of its (i) Retirement Facilities First Mortgage Revenue Bonds (EveryAge) Series 2021A (the "Series 2021A Bonds"), (ii) Taxable Retirement Facilities First Mortgage Revenue Refunding Bonds (EveryAge) Series 2021B (the "Series 2021B Bonds"), (iii) Taxable Retirement Facilities First Mortgage Revenue Refunding Bonds (EveryAge) Series 2021C (the "Series 2021C Bonds") and (iv) Taxable Retirement Facilities First Mortgage Revenue Refunding Bonds (EveryAge) Series 2021D (the "Series 2021D Bonds," and together with the Series 2021B Bonds and the Series 2021C Bonds, the "Taxable Bonds");

WHEREAS, pursuant to the Plan of Finance, the Commission also proposes to provide for the future sale and issuance by the Commission of three subsequent series of tax-exempt bonds entitled the North Carolina Medical Care Commission Retirement Facilities First Mortgage Revenue Refunding Bonds (EveryAge), Series 20__ (the "Future Tax-Exempt Bonds" and, together with the Taxable Bonds and the Series 2021A Bonds, the "Bonds") in an aggregate principal amount equal to the outstanding principal amount of the Taxable Bonds at the time of issuance of the Future Tax-Exempt Bonds for the purpose of refunding and redeeming the Taxable Bonds;

WHEREAS, the Commission has determined that the public will best be served by the proposed Plan of Finance described above, and, by resolution adopted by the Board of Directors of the Commission on August 13, 2021, has approved the issuance of the Bonds, subject to compliance by the Corporation with the conditions set forth in such resolution, and the Corporation has complied with such conditions to the satisfaction of the Commission;

WHEREAS, there have been presented to the officers and staff of the Commission the Preliminary Official Statement, dated September 14, 2021 (the "Preliminary Official Statement") with respect to the Series 2021A Bonds, and draft copies of the following documents relating to the issuance of the Bonds:

(a) the Contract of Purchase, to be dated the date of sale of the Series 2021A Bonds (the "2021A Contract of Purchase"), between the North Carolina Local Government Commission (the "LGC") and B.C. Ziegler & Company (the "Underwriter"), and approved by the Commission and the Corporation;

(b) the Contract of Purchase, to be dated the date of the issuance and sale of the Taxable Bonds or such other dated as shall be agreed upon by the parties thereto (the "Taxable Bonds Contract of Purchase"), between the LGC and Truist Bank (the "Purchaser"), and approved by the Commission and the Corporation;

(c) Obligation No. 20, to be dated the date of delivery ("Obligation No. 20"), to be issued by the Corporation to the Commission and assigned by the Commission to the 2021A Bond Trustee;

(d) Supplemental Indenture for Obligation No. 20, dated as of October 1, 2021 ("Supplemental Indenture No. 20"), by and between the Corporation and The Bank of New York Mellon Trust Company, N.A., as master trustee (the "Master Trustee"), supplementing and amending the Amended and Restated Master Trust Indenture, dated as of April 1, 2005 (as amended, the "Master Indenture"), by and among the Corporation, Lake Prince and the Master Trustee, with respect to the issuance of Obligation No. 20;

(e) Obligation No. 21, to be dated the date of delivery ("Obligation No. 21"), to be issued by the Corporation to the Commission and assigned by the Commission to the 2021B Bond Trustee;

(f) Supplemental Indenture for Obligation No. 21, dated as of October 1, 2021 ("Supplemental Indenture No. 21"), by and between the Corporation and the Master Trustee, supplementing the Master Indenture, with respect to the issuance of Obligation No. 21;

(g) Obligation No. 22, to be dated the date of delivery ("Obligation No. 22"), to be issued by the Corporation to the Purchaser;

(h) Supplemental Indenture for Obligation No. 22, dated as of October 1, 2021 ("Supplemental Indenture No. 22"), by and between the Corporation and the Master Trustee, supplementing the Master Indenture, with respect to the issuance of Obligation No. 22;

(i) Obligation No. 23, to be dated the date of delivery ("Obligation No. 23"), to be issued by the Corporation to the Commission and assigned by the Commission to the 2021C Bond Trustee;

(j) Supplemental Indenture for Obligation No. 23, dated as of October 1, 2021 ("Supplemental Indenture No. 23"), by and between the Corporation and the Master Trustee, supplementing the Master Indenture, with respect to the issuance of Obligation No. 23;

(k) Obligation No. 24, to be dated the date of delivery ("Obligation No. 24"), to be issued by the Corporation to the Purchaser;

(l) Supplemental Indenture for Obligation No. 24, dated as of October 1, 2021 ("Supplemental Indenture No. 24"), by and between the Corporation and the Master Trustee, supplementing the Master Indenture, with respect to the issuance of Obligation No. 24;

(m) Obligation No. 25, to be dated the date of delivery ("Obligation No. 25"), to be issued by the Corporation to the Commission and assigned by the Commission to the 2021D Bond Trustee;

(n) Supplemental Indenture for Obligation No. 25, dated as of October 1, 2021 ("Supplemental Indenture No. 25"), by and between the Corporation and the Master Trustee, supplementing the Master Indenture, with respect to the issuance of Obligation No. 25;

(o) Obligation No. 26, to be dated the date of delivery ("Obligation No. 26"), to be issued by the Corporation to the Purchaser;

(p) Supplemental Indenture for Obligation No. 26, dated as of October 1, 2021 ("Supplemental Indenture No. 26"), by and between the Corporation and the Master Trustee, supplementing the Master Indenture, with respect to the issuance of Obligation No. 26;

(q) Obligation No. 27, Obligation No. 28, Obligation No. 29 and Obligation No. 30, each to be dated the date of delivery (the "Swap Obligations"), to be issued by the Corporation to Truist Bank, as swap provider;

(r) Supplemental Indenture for Obligation Nos. 27, 28, 29 and 30, dated as of October 1, 2021 (the "Swap Supplemental Indenture"), by and between the Corporation and the Master Trustee, supplementing the Master Indenture, with respect to the Swap Obligations;

(s) a form of the Obligations to be issued by the Corporation to the Commission and assigned to the respective Taxable Bond Trustee related to the Future Tax-Exempt Bonds, each to be dated the date of their delivery (the "Future Tax-Exempt Obligations");

(t) a form for the Supplemental Indenture for the Future Tax-Exempt Obligations, (the "Future Supplemental Indentures"), by and between the Corporation and the Master Trustee, supplementing the Master Indenture;

(u) the Trust Agreement, dated as of October 1, 2021 (the "2021A Trust Agreement"), by and between the Commission and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "2021A Bond Trustee"), the provisions of which relate to the issuance of and security for the Series 2021A Bonds;

(v) the Trust Agreement, dated as of October 1, 2021 (the "2021B Trust Agreement"), by and between the Commission and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "2021B Bond Trustee"), the provisions of which relate to the issuance of and security for the Series 2021B Bonds and the Future Tax-Exempt Bonds that will refund the Series 2021B Bonds;

(w) the Trust Agreement, dated as of October 1, 2021 (the "2021C Trust Agreement"), by and between the Commission and The Bank of New York Mellon Trust

Company, N.A., as bond trustee (the "2021C Bond Trustee"), the provisions of which relate to the issuance of and security for the Series 2021C Bonds and the Future Tax-Exempt Bonds that will refund the Series 2021C Bonds;

(x) the Trust Agreement, dated as of October 1, 2021 (the "2021D Trust Agreement" and together with the 2021A Trust Agreement, the 2021B Trust Agreement and the 2021C Trust Agreement, the "Trust Agreements"), by and between the Commission and The Bank of New York Mellon Trust Company, N.A., as bond trustee (the "2021D Bond Trustee" and together with the 2021B Bond Trustee and the 2021C Bond Trustee, the "Taxable Bond Trustee"), the provisions of which relate to the issuance of and security for the Series 2021D Bonds and the Future Tax-Exempt Bonds that will refund the Series 2021D Bonds;

(y) the Loan Agreement, dated as of October 1, 2021 (the "2021A Loan Agreement"), by and between the Commission and the Corporation, pursuant to which the Commission will lend the proceeds of the Series 2021A Bonds to the Corporation;

(z) the Loan Agreement, dated as of October 1, 2021 (the "2021B Loan Agreement"), by and between the Commission and the Corporation, pursuant to which the Commission will lend the proceeds of the Series 2021B Bonds to the Corporation;

(aa) the Loan Agreement, dated as of October 1, 2021 (the "2021C Loan Agreement"), by and between the Commission and the Corporation, pursuant to which the Commission will lend the proceeds of the Series 2021C Bonds to the Corporation;

(bb) the Loan Agreement, dated as of October 1, 2021 (the "2021D Loan Agreement" and together with the 2021A Loan Agreement, the 2021B Loan Agreement and the 2021C Loan Agreement, the "Loan Agreements"), by and between the Commission and the Corporation, pursuant to which the Commission will lend the proceeds of the Series 2021D Bonds to the Corporation;

(cc) the Continuing Covenants Agreement, to be dated as of October 1, 2021 or such other date as shall be agreed upon by the parties thereto (the "2021B Covenant Agreement"), among the Corporation, Lake Prince, Lake Prince At Home, LLC ("Lake Prince At Home") and the Purchaser with respect to the Series 2021B Bonds and the Future Tax-Exempt Bonds that will replace the Series 2021B Bonds;

(dd) the Continuing Covenants Agreement, to be dated as of October 1, 2021 or such other date as shall be agreed upon by the parties thereto (the "2021C Covenant Agreement"), among the Corporation, Lake Prince, Lake Prince At Home, and the Purchaser with respect to the Series 2021C Bonds and the Future Tax-Exempt Bonds that will replace the Series 2021C Bonds;

(ee) the Continuing Covenants Agreement, to be dated as of October 1, 2021 or such other date as shall be agreed upon by the parties thereto (the "2021D Covenant Agreement"), among the Corporation, Lake Prince, Lake Prince At Home, and the Purchaser with respect to the Series 2021D Bonds and the Future Tax-Exempt Bonds that will replace the Series 2021D Bonds;

(ff) the Ninth Amendment to Amended and Restated Deed of Trust, dated as of October 1, 2021 (the "Lake Prince Amendment"), among Lake Prince, Mark D. Williamson, as Deed of Trust Trustee, and the Master Trustee, amending the Amended and Restated Deed of Trust, dated as of April 1, 2005, as amended (the "Lake Prince Deed of Trust"), from Lake Prince to Mark D. Williamson and Karen L. Duncan, as Deed of Trust Trustees, for the benefit of the Master Trustee, with respect to certain real property of Lake Prince located in the City of Suffolk, Virginia;

(gg) the Tenth Amendment to Amended and Restated Deed of Trust, dated as of October 1, 2021 (the "Piedmont Crossing Amendment"), among the Corporation, Chicago Title Insurance Company, as substitute Deed of Trust Trustee, and the Master Trustee, amending the Amended and Restated Deed of Trust, dated as of April 1, 2005, as amended (the "Piedmont Crossing Deed of Trust"), from the Corporation to The Fidelity Company, as Deed of Trust Trustee, for the benefit of the Master Trustee, with respect to certain real property of the Corporation located in Davidson County, North Carolina;

(hh) the Ninth Amendment to Amended and Restated Deed of Trust, dated as of October 1, 2021 (the "Abernethy Laurels Amendment" and, together with the Lake Prince Amendment and the Piedmont Crossing Amendment, the "Amendments to the Deeds of Trust"), among the Corporation, Chicago Title Insurance Company, as substitute Deed of Trust Trustee, and the Master Trustee, amending the Amended and Restated Deed of Trust, dated as of April 1, 2005, as amended (the "Abernethy Laurels Deed of Trust" and, together with the Lake Prince Deed of Trust and the Piedmont Crossing Deed of Trust, the "Deeds of Trust"), from the Corporation to The Fidelity Company, as Deed of Trust Trustee, for the benefit of the Master Trustee, with respect to certain real property of the Corporation located in Catawba County, North Carolina;

(ii) Escrow Deposit Agreement, dated as of October 1, 2021 (the "2015 Escrow Agreement"), among the Commission, the Corporation and The Bank of New York Mellon Trust Company, N.A., as escrow agent (the "2015 Escrow Agent") relating to the refunding of Series 2015A Bonds; and

(jj) Escrow Deposit Agreement, dated as of October 1, 2021 (the "2017C Escrow Agreement"), among the Commission, the Corporation and The Bank of New York Mellon Trust Company, N.A., as escrow agent (the "2017C Escrow Agent") relating to the refunding of Series 2017C Bonds;

WHEREAS, the Commission has determined that, taking into account the historical financial performance of the Members of the Obligated Group (as defined in the Master Indenture) and financial forecasts internally generated by the Corporation, (i) the Members of the Obligated Group are financially responsible and capable of fulfilling their respective obligations under the Master Indenture, Obligation No. 20, Obligation No. 21, Obligation No. 22, Obligation No. 23, Obligation No. 24, Obligation No. 25, Obligation No. 26, Obligation No. 27, Obligation No. 28, Obligation No. 29, Obligation No. 30, the Future Tax-Exempt Obligations, Supplemental Indenture No. 20, Supplemental Indenture No. 21, Supplemental Indenture No. 22, Supplemental Indenture No. 23, Supplemental Indenture No. 24, Supplemental Indenture No. 25, Supplemental Indenture No. 26, the Swap Supplemental Indenture, the Future Supplemental Indentures and the

Deeds of Trust and (ii) the Corporation is financially responsible and capable of fulfilling its obligations under the Loan Agreements; and

WHEREAS, the Commission has determined that the public interest will be served by the proposed financing and that, taking into account the historical financial performance of the Members of the Obligated Group and financial forecasts internally generated by the Corporation, adequate provision has been made for the payment of the principal of, redemption premium, if any, and interest on the Bonds;

NOW, THEREFORE, THE EXECUTIVE COMMITTEE OF THE NORTH CAROLINA MEDICAL CARE COMMISSION DOES HEREBY RESOLVE, as follows:

Section 1. **Defined Terms.** Capitalized words and terms used in this Series Resolution and not defined herein shall have the same meanings in this Series Resolution as such words and terms are given in the Trust Agreements and the Loan Agreements.

Section 2. **Authorization of Bonds.** Pursuant to the authority granted to it by the Act, the Commission hereby authorizes the issuance of the Bonds in the aggregate principal amount of $76,140,000, consisting of $22,205,000 of Series 2021A Bonds, $4,240,000 of Series 2021B Bonds, $31,310,000 of Series 2021C Bonds and $18,385,000 of Series 2021D Bonds. The Bonds shall mature in such amounts and at such times, be subject to Sinking Fund Requirements and bear interest at such rates as are set forth in Schedule 1 attached hereto.

The Series 2021A Bonds shall be dated the date of their issuance and delivery and shall be issued as fully registered bonds in denominations of $5,000 or any whole multiple thereof. The Series 2021A Bonds shall be issued in book-entry-only form as described in the 2021A Trust Agreement. Interest on the Series 2021A Bonds shall be paid on each March 1 and September 1, beginning on March 1, 2022, to and including September 1, 2051. Payments of principal of and interest on the Series 2021A Bonds shall be forwarded by the 2021A Bond Trustee to the registered owners of the Series 2021A Bonds in such manner as is set forth in the 2021A Trust Agreement.

The Taxable Bonds shall be dated the date of their issuance and delivery and shall be issued as fully registered bonds, initially in the denominations of $1.00, while the Taxable Bonds bear interest at the Bank-Bought Rate (as defined the respective Trust Agreement).

The Future Tax-Exempt Bonds shall be dated the date of their issuance and delivery and shall be issued as fully registered bonds. Each series of Future Tax-Exempt Bonds shall be issued in a principal amount equal to the outstanding principal amount of the respective series of Taxable Bonds for which such Future Tax-Exempt Bond it is being issued to replace, as described in the 2021B Trust Agreement, the 2021C Trust Agreement and the 2021D Trust Agreement, as applicable.

Commencing on the date of Closing, the Taxable Bonds shall bear interest at the Bank-Bought Rate as set forth on Schedule 1 and made a part hereof. Interest on the Bonds shall be payable on each Interest Payment Date. The Bank-Bought Minimum Holding Period for the Bonds shall commence on the Closing Date and shall end on October 1, 2036. The Taxable Bonds may be converted to bear interest under another Interest Rate Determination Method as

provided in the 2021B Trust Agreement, the 2021C Trust Agreement and the 2021D Trust Agreement, as applicable.

Section 3. Redemption. (a) The Series 2021A Bonds shall be subject to mandatory, extraordinary and optional redemption at the times, upon the terms and conditions, and at the prices set forth in the 2021A Trust Agreement.

(b) The Taxable Bonds shall be subject to optional and extraordinary optional redemption at the times, upon the terms and conditions, and at the price set forth in the respective Trust Agreement. The Taxable Bonds shall also be subject to mandatory sinking fund redemption as set forth on Schedule 1 and made a part hereof.

Section 4. Optional and Mandatory Tender for Purchase. The Taxable Bonds and the Future Tax-Exempt Bonds shall be subject to optional and mandatory tender for purchase at the times, upon the terms and conditions, and at the price set forth in the 2021B Trust Agreement, the 2021C Trust Agreement and the 2021D Trust Agreement, as applicable.

Section 5. Use of Bond Proceeds. The proceeds of the Bonds shall be applied as provided in the respective Trust Agreement. The Commission hereby finds that the use of the proceeds of the Bonds for a loan to the Corporation for the purposes described in the preamble to this Series Resolution will accomplish the public purposes set forth in the Act.

Section 6. Authorization of Loan Agreement and Trust Agreement. The forms, terms and provisions of the Trust Agreements and the Loan Agreements are hereby approved in all respects, and the Chairman, the Vice Chairman or any member of the Commission designated in writing by the Chairman of the Commission for such purpose and the Secretary or the Assistant Secretary of the Commission are hereby authorized and directed to execute and deliver the Trust Agreements and the Loan Agreements in substantially the forms presented to this meeting, together with such changes, modifications and deletions, as they, with the advice of counsel, may deem necessary and appropriate, including, but not limited to, changes, modifications and deletions necessary to incorporate the final terms of the Bonds as shall be set forth in the 2021A Contract of Purchase and the Taxable Bonds Contract of Purchase, as applicable; such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 7. Authorization of the 2021A Contract of Purchase and the Taxable Bonds Contract of Purchase. The form, terms and provisions of the 2021A Contract of Purchase and the Taxable Bonds Contract of Purchase are hereby approved in all respects and the Chairman, the Vice Chairman or any member of the Commission designated in writing by the Chairman of the Commission for such purpose is hereby authorized and directed to approve, by execution and delivery, the 2021A Contract of Purchase and the Taxable Bonds Contract of Purchase in substantially the forms presented to this meeting, together with such changes, modifications, insertions and deletions as the Chairman, the Vice Chairman or such member of the Commission, with the advice of counsel, may deem necessary and appropriate; such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 8. **Form of Bonds**. The forms of the Bonds set forth in the respective Trust Agreement are hereby approved in all respects and the Chairman, the Vice Chairman or any member of the Commission designated in writing by the Chairman of the Commission for such purpose and the Secretary or the Assistant Secretary of the Commission are hereby authorized and directed to execute, by manual or facsimile signature as provided in such forms of the Bonds, and to deliver to the respective Bond Trustee for authentication on behalf of the Commission, the respective Bonds in definitive form, which shall be in substantially the forms presented to this meeting, together with such changes, modifications and deletions as they, with the advice of counsel, may deem necessary, appropriate and consistent with the respective Trust Agreement; such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 9. **Approval of Other Financing Documents.** The forms, terms and provisions of Supplemental Indenture No. 20, Obligation No. 20, Supplemental Indenture No. 21, Obligation No. 21, Supplemental Indenture No. 22, Obligation No. 22, Supplemental Indenture No. 23, Obligation No. 23, Supplemental Indenture No. 24, Obligation No. 24, Supplemental Indenture No. 25, Obligation No. 25, Supplemental Indenture No. 26, Obligation No. 26, Future Tax-Exempt Obligations, Future Supplemental Indenture, Swap Supplemental Indenture, the Swap Obligations, the 2021B Covenant Agreement, the 2021C Covenant Agreement, 2021D Covenant Agreement, the 2015 Escrow Agreement, the 2017C Escrow Agreement, and the Amendments to the Deeds of Trust (collectively, the "Other Financing Documents") are hereby approved in substantially the forms presented at this meeting, together with such changes, modifications and deletions as the Chairman, the Vice Chairman or any member of the Commission designated in writing by the Chairman of the Commission, with the advice of counsel, may deem necessary and appropriate; the execution and delivery of the Trust Agreements pursuant to Section 6 of this Series Resolution shall be conclusive evidence of the approval of the Other Financing Documents by the Commission.

Section 10. **Purchase of Bonds.** (a) The Commission hereby approves the action of the Local Government Commission in awarding the Series 2021A Bonds to the Underwriter at the purchase price of $24,698,577.95 (representing the principal amount of the Series 2021A Bonds, plus original issue premium of $2,754,486.70, less an Underwriter’s discount of $260,908.75).

Upon their execution in the form and manner set forth in the 2021A Trust Agreement, the Series 2021A Bonds shall be deposited with the 2021A Bond Trustee for authentication, and the 2021A Bond Trustee is hereby authorized and directed to authenticate the Series 2021A Bonds and, upon satisfaction of the provisions of the 2021A Trust Agreement, the 2021A Bond Trustee shall deliver the Series 2021A Bonds to the Underwriter against payment therefor.

(b) The Commission hereby approves the action of the Commission in awarding the Taxable Bonds to the Purchaser at an aggregate price not exceeding $53,935,000 (representing the maximum aggregate principal amount of the Taxable Bonds). The Corporation will separately pay, on the date of Closing, the Purchaser an aggregate fee of $53,935 in consideration for such purchase.

Payment for the Future Tax-Exempt Bonds by the Purchaser shall be made at the purchase price of 100% of so much of the principal amount of the respective Taxable Bonds for which such Future Tax-Exempt Bond is designated to replace pursuant to the 2021B Trust Agreement, 2021C Trust Agreement, 2021D Trust Agreement, the 2021B Covenant Agreement, 2021C Covenant Agreement, and 2021D Covenant Agreement, as applicable.

Upon their execution in the forms and manner set forth in the 2021B Trust Agreement, 2021C Trust Agreement, and 2021D Trust Agreement, as applicable, the Taxable Bonds shall be deposited with the Taxable Bond Trustee for authentication, and the Taxable Bond Trustee is hereby authorized and directed to authenticate the Taxable Bonds and, upon satisfaction of the provisions of the 2021B Trust Agreement, 2021C Trust Agreement, and 2021D Trust Agreement, as applicable, the Taxable Bond Trustee shall deliver the Taxable Bonds to the Purchaser against payment therefor.

Upon their execution in the forms and manner set forth in the 2021B Trust Agreement, 2021C Trust Agreement, and 2021D Trust Agreement, as applicable, the Future Tax-Exempt Bonds shall be deposited with the Taxable Bond Trustee for authentication, and the Taxable Bond Trustee is hereby authorized and directed to authenticate the Future Tax-Exempt Bonds and, upon satisfaction of the provisions of the 2021B Trust Agreement, 2021C Trust Agreement, and 2021D Trust Agreement, as applicable, the Taxable Bond Trustee shall deliver the Future Tax-Exempt Bonds to the Purchaser to replace the respective series of Taxable Bonds.

Section 11. **Offering Documents for Serie 2021A Bonds.** The Commission hereby approves and ratifies the use and distribution of the Preliminary Official Statement and approves the use and distribution of a final Official Statement (the "Official Statement"), both in connection with the offer and sale of the Series 2021A Bonds, and the Chairman, the Vice Chairman or any member of the Commission designated in writing by the Chairman of the Commission for such purpose is hereby authorized to execute, on behalf of the Commission, the Official Statement in substantially the form of the Preliminary Official Statement, together with such changes, modifications and deletions as the Chairman, the Vice Chairman or such member of the Commission, with the advice of counsel, may deem necessary and appropriate. Such execution shall be conclusive evidence of the approval thereof by the Commission. The Commission hereby approves and authorizes the distribution and use of copies of the Official Statement, the 2021A Trust Agreement, the 2021A Loan Agreement, the Master Indenture, Supplemental Indenture No. 20, Obligation No. 20, the Amendments to the Deeds of Trust and the Deeds of Trust by the Underwriter in connection with such offering and sale of the Series 2021A Bonds.

Section 12. **DTC.** The Depository Trust Company ("DTC"), New York, New York, is hereby appointed as the initial Securities Depository for the Series 2021A Bonds, with Cede & Co., as nominee of DTC, being the initial Securities Depository Nominee and initial registered owner of the Series 2021A Bonds. The Commission has heretofore executed and delivered to DTC a Blanket Letter of Representations.

Section 13. **Bond Trustee and Escrow Agent.** The Bank of New York Mellon Trust Company, N.A. is hereby appointed the 2021ABond Trustee, the Taxable Bond Trustee, the 2015 Escrow Agent and the 2017C Escrow Agent.

Section 14. Commission Representatives. S. Mark Payne, Secretary of the Commission, Geary Knapp, Assistant Secretary of the Commission, and Crystal Watson-Abbott, Auditor to the Commission, are each hereby appointed a Commission Representative, with full power to carry out the duties set forth therein.

Section 15. Ancillary Actions. The Chairman, the Vice Chairman, any member of the Commission designated in writing by the Chairman of the Commission, the Secretary and the Assistant Secretary of the Commission are authorized and directed (without limitation except as may be expressly set forth herein) to take such action and to execute and deliver any such documents, certificates, undertakings, consents, agreements or other instruments, as they, with the advice of counsel, may deem necessary or appropriate to effect the transactions, including the refunding of the Prior Bonds, contemplated by the Trust Agreements, the Loan Agreements, the Master Indenture, the Deeds of Trust, the 2021A Contract of Purchase, the Taxable Bonds Contract of Purchase, the Other Financing Documents and the Official Statement.

Section 16. Professional Fees. A comparison of the professional fees as set forth in the resolution of the Executive Committee of the Commission granting preliminary approval of this financing with the actual professional fees incurred in connection with the financing is set forth in Schedule 2 attached hereto.

Section 17. Effective Date. This Series Resolution shall take effect immediately upon its passage.

Schedule 1

Maturity Schedule

Term Series 2021A Bonds

$6,540,000 4.000% Term Bonds due September 1, 2041

Due September 1	Sinking Fund Requirement
2032	$295,000
2033	315,000
2034	330,000
2035	340,000
2036	350,000
2037	370,000
2038	1,075,000
2039	1,085,000
2040	1,190,000
2041*	1,190,000

* Maturity

$11,815,000 4.000% Term Bonds due September 1, 2047

Due September 1	Sinking Fund Requirement
2042	$1,295,000
2043	1,305,000
2044	1,410,000
2045	1,420,000
2046	1,675,000
2047*	4,710,000

* Maturity

$3,850,000 4.000% Term Bonds due September 1, 2051

Due September 1	Sinking Fund Requirement
2048	$905,000
2049	945,000
2050	980,000
2051*	1,020,000

* Maturity

Series 2021B Bonds

Taxable Interest Rate: Daily Simple SOFR plus 1.50%

Future Tax-Exempt Interest Rate*: 79% of Daily Simple SOFR plus 1.185%

Sinking Fund Requirements

Due September 1	Sinking Fund Requirement
2022	$355,000
2023	335,000
2024	335,000
2025	330,000
2026	325,000
2027	315,000
2028	395,000
2029	445,000
2030	645,000
2031	15,000
2032	115,000
2033	120,000
2034	120,000
2035	130,000
2036	130,000
2037	130,000

* A series of Future Tax-Exempt Bonds will be issued to refund the Series 2021B Bonds, as further described in the 2021B Trust Agreement and the 2021B Covenant Agreement.

Series 2021C Bonds

Taxable Interest Rate: Daily Simple SOFR plus 1.50%

Future Tax-Exempt Interest Rate*: 79% of Daily Simple SOFR plus 1.185%

Sinking Fund Requirements

Due September 1	Sinking Fund Requirement
2022	$1,510,000
2023	1,575,000
2024	1,435,000
2025	105,000
2026	105,000
2027	110,000
2028	115,000
2029	115,000
2030	115,000
2031	120,000
2032	125,000
2033	125,000
2034	130,000
2035	135,000
2036	140,000
2037	140,000
2038	2,545,000
2039	2,645,000
2040	2,655,000
2041	2,770,000
2042	2,785,000
2043	2,905,000
2044	2,925,000
2045	3,050,000
2046	2,930,000

* A series of Future Tax-Exempt Bonds will be issued to refund the Series 2021C Bonds, as further described in the 2021C Trust Agreement and the 2021C Covenant Agreement.

Series 2021D Bonds

Taxable Interest Rate: Daily Simple SOFR plus 1.50%

Future Tax-Exempt Interest Rate*: 79% of Daily Simple SOFR plus 1.185%

Sinking Fund Requirements

Due September 1	Sinking Fund Requirement
2022	$195,000
2023	215,000
2024	190,000
2025	110,000
2026	110,000
2027	115,000
2028	115,000
2029	120,000
2030	125,000
2031	830,000
2032	2,540,000
2033	2,605,000
2034	2,670,000
2035	2,740,000
2036	2,815,000
2037	2,890,000

* A series of Future Tax-Exempt Bonds will be issued to refund the Series 2021D Bonds, as further described in the 2021D Trust Agreement and the 2021D Covenant Agreement.

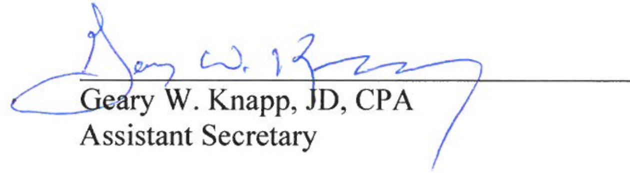
Schedule 2

Professional Fees

Professional	Preliminary Approval	Actual
Underwriter/Placement Agent	$510,000	$530,584
Accountant/Auditor	25,000	30,000
Bond Counsel	175,000	175,000
Underwriter's Counsel	65,000	65,000
Corporation Counsel	25,000	30,000
Trustee (including counsel)	20,000	25,500
Rating Agencies	49,975	25,000
Printing	10,000	4,500
Commission	8,750	8,750
Blue Sky Counsel	3,500	5,000
Real Estate	80,000	35,200
Bank Commitment Fee	60,000	60,000
Bank Counsel	50,000	50,000
Verification Agent	6,000	2,800
Swap Advisor	75,000	65,000
Contingency	9,975	-
Virginia Special Counsel	-	5,000

3. There being no further business, the meeting was adjourned at 11:55 a.m.

Respectfully submitted,



Geary W. Knapp, JD, CPA
Assistant Secretary

NC MCC Bond Sale Approval Form
Facility Name: United Church Homes and Services

SERIES:	Time of Preliminary Approval 2021A Taxable Term Loan	Time of Mailing POS (if applicable)	Time of Final Approval	Total Variance	Explanation of Variance
PAR Amount	$55,000,000		$53,935,000.00		
Estimated Interest Rate	2.00%		1.75%		
All-in True Interest Cost	2.05%		1.80%		
Maturity Schedule (Interest) - Date	10/01/21 - 09/01/24		11/1/2021 - 9/1/2024		
Maturity Schedule (Principal) - Date	10/01/21 - 09/01/24		11/1/2021 - 9/1/2024		
Bank Holding Period (if applicable) - Date	Full Maturity (09/01/24)		Full Maturity (09/01/24)		
Estimated NPV Savings ($) (if refunded bonds)	See Below		See below		
Estimated NPV Savings (%) (if refunded bonds)	See Below		See below		
NOTES:	Refunded with 3 Bank Series Noted Below. Actual taxable loans are broken into 3 separate series but combination matches original approval concep				

SERIES:	Time of Preliminary Approval 2021B (2022A Tax Exempt)	Time of Mailing POS (if applicable)	Time of Final Approval 2021B (2022A Tax Exempt)	Total Variance	Explanation of Variance
PAR Amount	$4,515,000		$4,240,000	($275,000)	Lower Rates
Estimated Interest Rate	2.80%		2.29%	-0.51%	Lower Rates
All-in True Interest Cost	2.96%		2.51%	-0.45%	Lower Rates
Maturity Schedule (Interest) - Date	10/1/2022 - 9/1/2037		11/1/2022 - 9/1/2037		
Maturity Schedule (Principal) - Date	10/1/2022 - 9/1/2037		11/1/2022 - 9/1/2037		
Bank Holding Period (if applicable) - Date	10/1/2036		11/1/2036		
Estimated NPV Savings ($) (if refunded bonds)	$256,862		$427,463	$170,601	Lower Rates
Estimated NPV Savings (%) (if refunded bonds)	6.01%		10.00%	3.99%	Lower Rates
NOTES:	Redeems portion of taxable term loan in June 2022				

SERIES:	Time of Preliminary Approval 2021C (2023A Tax Exempt)	Time of Mailing POS (if applicable)	Time of Final Approval 2021C (2023A Tax Exempt)	Total Variance	Explanation of Variance
PAR Amount	$31,615,000		$31,310,000.00	($305,000.00)	Lower Rates
Estimated Interest Rate	3.13%		2.51%	-0.62%	Lower Rates
All-in True Interest Cost	3.18%		2.63%	-0.55%	Lower Rates
Maturity Schedule (Interest) - Date	10/1/2022 - 9/1/2046		11/1/2022 - 9/1/2046		
Maturity Schedule (Principal) - Date	10/1/2022 - 9/1/2046		11/1/2022 - 9/1/2046		
Bank Holding Period (if applicable) - Date	10/1/2036		10/1/2036		
Estimated NPV Savings ($) (if refunded bonds)	$3,703,638		$6,749,231	$3,045,593	Lower Rates
Estimated NPV Savings (%) (if refunded bonds)	12.53%		22.83%	10.30%	Lower Rates
NOTES:	Redeems portion of taxable term loan in June 2022				

	Time of Preliminary Approval	Time of Mailing POS (if applicable)	Time of Final Approval	Total Variance	Explanation of Variance
SERIES:	**2021D (2024A Tax Exempt)**		**2021D (2024A Tax Exempt)**		
PAR Amount	$18,420,000		$18,385,000.00	($35,000.00)	Lower Rates
Estimated Interest Rate	3.04%		2.50%	-0.54%	Lower Rates
All-in True Interest Cost	3.11%		2.64%	-0.47%	Lower Rates
Maturity Schedule (Interest) - Date	10/1/2022 - 9/1/2037		11/1/2022 - 9/1/2037		
Maturity Schedule (Principal) - Date	10/1/2022 - 9/1/2037		11/1/2022 - 9/1/2037		
Bank Holding Period (if applicable) - Date	10/1/2036		10/1/2036		
Estimated NPV Savings ($) (if refunded bonds)	$967,854		$2,307,363	$1,339,509.00	Lower Rates
Estimated NPV Savings (%) (if refunded bonds)	5.71%		13.61%	7.90%	Lower Rates
NOTES:	Redeems portion of taxable term loan in June 2022				

	Time of Preliminary Approval	Time of Mailing POS (if applicable)	Time of Final Approval	Total Variance	Explanation of Variance
SERIES:	**2021A**	**2021A**			
PAR Amount	$25,500,000	$22,370,000.00	$22,205,000.00	($165,000.00)	Higher Premium Reduced Par
Estimated Interest Rate	4.00% Coupon (Yields 1.36%-3.54%)	4.00% Coupon (Yields 0.93%-2.63%)	4.00% Coupon (Yields 2.26%-2.59%)		
All-in True Interest Cost	3.61%	3.39%	3.34%	-0.05%	Lower Rates
Maturity Schedule (Interest) - Date	3/1/2022 - 9/1/2051	3/1/2022 - 9/1/2051	3/1/2023 - 9/1/2051		
Maturity Schedule (Principal) - Date	9/1/2032 - 9/1/2051	9/1/2032 - 9/1/2051	9/1/2032 - 9/1/2051		
Bank Holding Period (if applicable) - Date	NA (Public Fixed Rate Bonds)	NA (Public Fixed Rate Bonds)	NA (Public Fixed Rate Bonds)		
Estimated NPV Savings ($) (if refunded bonds)	Refunding for Structure	Refunding for Structure	Refunding for Structure		
Estimated NPV Savings (%) (if refunded bonds)	Refunding for Structure	Refunding for Structure	Refunding for Structure		
NOTES:	Refunding for structuring to minimize expsoure to interest rate risk				

NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

The North Carolina Medical Care Commission
809 Ruggles Drive
Raleigh, North Carolina

MINUTES

CALLED MEETING OF THE EXECUTIVE COMMITTEE
CONFERENCE TELEPHONE MEETING ORIGINATING FROM THE COMMISSION'S OFFICE
OCTOBER 21, 2021
11:30 A.M.

Members of the Executive Committee Present:

John J. Meier, IV, Chairman
Joseph D. Crocker, Vice-Chairman
Sally B. Cone
Bryant C. Foriest
Eileen C. Kugler, RN, MSN, MPH, FNP
Jeffrey S. Wilson

Members of the Executive Committee Absent:

Linwood B. Hollowell, III

Members of Staff Present:

Geary W. Knapp, JD, CPA, Assistant Secretary
Kathy C. Larrison, MCC Auditor
Crystal Watson-Abbott, MCC Auditor
Alice S. Creech, Executive Assistant

Others Present:

Tommy Brewer, Ziegler
Jonathan Erickson, United Methodist Retirement Homes
Stacy Dobson, United Methodist Retirement Homes

1. **Purpose of Meeting**

To consider preliminary approval to a transaction for United Methodist Retirement Homes, Inc.

2. **The United Methodist Retirement Homes, Inc. – Durham, Greenville, Lumberton**

Resolution: The Commission grants preliminary approval to a transaction for United Methodist Retirement Homes, Inc. to provide funds, to be used, together with other available funds, to **(1) advance refund**, on a *taxable* basis, the North Carolina Medical Care Commission $8,370,000 Retirement Facilities First Mortgage Revenue Refunding Bonds (The United Methodist Retirement Homes), Series 2013A, currently outstanding in the amount of $8,160,000; **(2) advance refund**, on a *taxable* basis, the North Carolina Medical Care Commission $71,970,000 Retirement Facilities First Mortgage Revenue and Revenue Refunding Bonds (The United Methodist Retirement Homes), Series 2017A, currently outstanding in the amount of $69,845,000; and **(3) enter a forward purchase agreement** that allows the exchange of the taxable refunding bonds for *tax-exempt* bonds within 90 days of the first optional call date (10/1/2023) of the Series 2013A and 2017A bonds. The proposed transaction in its entirety will result in an estimated NPV savings of $9,030,579. The proposed transaction is in accordance with an application received as follows:

ESTIMATED SOURCES OF FUNDS

Principal amount of bonds to be issued	$81,175,000
Debt Service Reserve Fund	6,161,858
Total Sources of Funds	**$87,336,858**

ESTIMATED USES OF FUNDS

Escrow Amount to refund Series 2013A & 2017A	$86,520,600
Underwriter Placement Fee	406,039
Bank Fee	101.469
Title/Recording Fee	25,000
SWAP Advisor	75,000
Verification Agent Fee	5,000
Local Government Commission Fee	8,750
Trustee & Trustee Counsel Fee	15,000
Corporation Counsel	35,000
Bank Purchaser Counsel	50,000
Bond Counsel	95,000
Total Uses	**$87,336,858**

Tentative approval is given with the understanding that the governing board of United Methodist Retirement Homes, Inc. accepts the following conditions:

1. The project will continue to be developed pursuant to the applicable Medical Care Commission guidelines.

2. Final financial feasibility must be determined prior to the issuance of bonds.

3. The project must, in all respects, meet requirements of G.S. § 131A (Health Care Facilities Finance Act).

4. The Executive Committee of the Commission is delegated the authority to approve the issuance of bonds for this project and may approve the issuance of such greater principal amount of the loan as shall be necessary to finance the project; provided, however, that the amount set forth above shall not be increased by more than ten percent (10%).

5. The bonds or notes shall be sold in such a manner and upon such terms and conditions as will, in the sole judgment of the Executive Committee of the Commission, result in the lowest cost to the facility and its residents.

6. If public approval of the bonds is required for the purpose of Section 147(f) of the Internal Revenue Code of 1986, as amended ("Section 147(f)"), this tentative approval shall constitute the recommendation of the Commission that the Governor of the State of North Carolina (the "Governor") approve the issuance of such bonds, subject to the satisfaction of the requirements of Section 147(f) concerning the holding of a public hearing prior to the submission of such recommendation to the Governor.

7. The borrower will comply with the Commission's Resolution: Community Benefits/Charity Care Agreement and Program Description for CCRCs as adopted.

8. The borrower will furnish, prior to the sale of or issuance of the bonds or notes or execution of the leases, evidence that it is in compliance with the covenants of all of its outstanding Medical Care Commission debt.

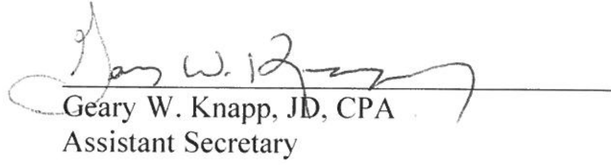
Based on information furnished by applicant, the project is -

1.	Financially feasible	✓ Yes	______ No	______ N/A
2.	Construction and related costs are reasonable	______ Yes	______ No	✓ N/A

EXECUTIVE COMMITTEE ACTION: *A motion was made to approve the resolution by Mr. Joe Crocker, seconded by Mrs. Eileen Kugler, and unanimously approved.*

3. There being no further business, the meeting was adjourned at 11:51 a.m.

Respectfully submitted,



Geary W. Knapp, JD, CPA
Assistant Secretary

EXHIBIT A

Compliance Summary:

- **Compliant with NCMCC Compliance Policy**

1) Does Organization have a formal post tax issuance compliance policy?
   Yes

2) Who in the Organization will be designated to ensure appropriate compliance with the issuance?
   CFO

3) What is the Organization's compliance monitoring plan?
   Annual reporting reviewed by the CFO

4) How will the Organization report compliance deficiencies to leadership and the Board?
   Any deficiencies would be reported in a Board of Directors meeting.

Selected Application Information:

1) Information from FYE 2020 (9/30 Year End) Audit of UMRH:

Net Income / (Loss)	$ 13,210,910
Operating Revenue	$ 76,002,281
Operating Expenses	$ 69,056,254
Net Cash provided by Operating Activities	$ 22,934,574
Change in Net Assets	$ 13,515,610
Unrestricted Cash	$ 5,663,881
Change in Cash	($ 24,521,683)

2) Ratings:

Not Rated

3) Community Benefits (FYE 2020):

Per N.C.G.S § 105 – 7.83% (Eligible for 100% property tax exclusion)

- Total Community Benefits and Charity Care - $6,143,725

4) Long-Term Debt Service Coverage Ratios:

Actual FYE 2020	3.09
Forecasted FYE 2021	2.27
Forecasted FYE 2022	1.89
Forecasted FYE 2023	1.96
Forecasted FYE 2024	2.11
Forecasted FYE 2025	2.28

5) Transaction Participants:

Bond Counsel:	Robinson, Bradshaw & Hinson, PA
Placement Agent:	B.C. Zeigler and Company
Bank Purchaser:	Truist Bank
Bank Counsel:	Moore & Van Allen PLLC
Trustee:	U.S. Bank National Association
Accountant (AUP Forecast):	Dixon Hughes Goodman LLP

6) Other Information:

(a) Board diversity

Male:	10
Female:	5
Total:	15

Caucasian:	13
African American:	2
	15

(b) Diversity of residents

Male:	342
Female:	717
Total:	1,059

Caucasian:	1,025
Asian:	3
Native American:	11
African American:	20
Total:	1,059

(c) Fee Schedule – Attached (See pages A-3 thru A-8)
(d) MCC Bond Sale Approval Policy Form – Attached (See page A-9)

Wesley Pines Retirement Community

Standard Fee Schedule 2021

Lifestyle	Entrance Fee	Monthly	Fee				
Health Center	*Not Applicable*						
SNF-Semi-Private		$266 Daily					
SNF Private		$281 Daily					
Assisted Living							
Rooms							
Parkton (306 sq. ft.)	$4,000	$4,360					
Fairmont (360 sq. ft.)	$5,000	$4,983					
Marietta (436 sq. ft.)	$7,000	$5,909					
Suites							
Rowland (420 sq. ft.)	$12,000	$5,909					
Pembroke (456 sq. ft.)	$15,000	$6,229	1st person				
		$1,436	2nd person				
	Standard	**Plan A**		**Plan B**		**Plan C**	
Cottage Duplexes		*1st Person*	*2nd Person*	*1st Person*	*2nd Person*	*1st Person*	*2nd Person*
Cottage	$62,773	$3,531	$1,246	$3,006	$1,019	$2,754	$790
Cottage 50% ROC	$83,680	$3,531	$1,246	$3,006	$1,019	$2,754	$790
Cottage 90% ROC	$125,599	$3,531	$1,246	$3,006	$1,019	$2,754	$790
Cottage w/Carport	$72,334	$3,531	$1,246	$3,006	$1,019	$2,754	$790
Cottage w/Carport 50% ROC	$96,445	$3,531	$1,246	$3,006	$1,019	$2,754	$790
Cottage w/Carport 90% ROC	$144,668	$3,531	$1,246	$3,006	$1,019	$2,754	$790
Villas							
Duplex Villa	$81,894	$3,587	$1,246	$3,057	$1,019	$2,794	$790
Duplex Villa 50% ROC	$109,210	$3,587	$1,246	$3,057	$1,019	$2,794	$790
Duplex Villa 90% ROC	$163,736	$3,587	$1,246	$3,057	$1,019	$2,794	$790
Free Standing Villa	$95,710	$3,587	$1,246	$3,057	$1,019	$2,794	$790
Free Standing Villa 50% ROC	$127,648	$3,587	$1,246	$3,057	$1,019	$2,794	$790
Free Standing Villa 90% ROC	$191,367	$3,587	$1,246	$3,057	$1,019	$2,794	$790
Deluxe Villa	$167,684	$3,659	$1,246	$3,115	$1,019	$2,862	$790
Deluxe Villa 50% ROC	$219,236	$3,659	$1,246	$3,115	$1,019	$2,862	$790
Deluxe Villa 90% ROC	$328,828	$3,659	$1,246	$3,115	$1,019	$2,862	$790

Monthly fees include all utilities except telephone.

Meal Plans

Plan A includes 3 meals daily in the Dining Room.
Plan B includes 1 meal daily in the Dining Room.
Plan C no meal plan/pay per meal.

Managed by Life Care Services™ EQUAL HOUSING OPPORTUNITY UMRH

Croasdaile Village

Independent Living Apartments and Cottages

SINGLE OCCUPANCY	Sq. Feet	Standard Entrance Fee*	Monthly Fee
Apartments			
Studio	400 +/-	$59,317	$2,074
Alcove	490 +/-	$73,095	$2,548
1 Bedroom Standard	770-840 +/-	$127,821	$3,103
1 Bedroom Traditional	850 +/-	$136,067	$3,172
1 Bedroom Deluxe	920 +/-	$159,570	$3,235
1 Bedroom w. Den	950 +/-	$175,188	$3,357
1 Bedroom Grande	965 +/-	$170,610	$3,406
2 Bedroom Traditional	1060 +/-	$194,759	$3,537
2 Bedroom Standard	1110-1190 +/-	$184,901	$3,588
2 Bedroom Conventional	1175 +/-	$202,323	$3,856
2 Bedroom Deluxe	1285 +/-	$209,979	$3,910
2 Bedroom w. Den	1350 +/-	$246,531	$4,233
2 Bedroom Grande	1350 +/-	$233,460	$4,229
2 Bedroom Grande II	1450 +/-	$251,187	$4,554
2 Bedroom Executive	1600 +/-	$276,902	$4,594
Park Homes - New Expansion			
Aspen	1404 +/-	$268,561	$3,781
Birch	1455 +/-	$278,316	$3,961
Maple	1675 +/-	$316,737	$4,077
Oak	1877 +/-	$348,780	$4,176
Duplex Cottages			
Appletree Duplex	1310 +/-	$222,207	$4,052
Beechwood Duplex	1510 +/-	$249,475	$4,128
Cottonwood Duplex	1640 +/-	$273,881	$4,230
Dogwood Duplex	1810 +/-	$293,550	$4,353
Elmwood Duplex	1940 +/-	$330,057	$4,618
Fernwood Duplex	1500 +/-	$261,836	$4,427
Greenwood Duplex	1700 +/-	$296,745	$4,446
Heartwood Duplex	1900 +/-	$354,459	$4,712
Duplex Cottages - New Expansion			
Fernwood II Duplex	1469 +/-	$280,995	$4,195
Greenwood II Duplex	1659 +/-	$317,338	$4,351
Heartwood II Duplex	1938 +/-	$379,179	$4,497
Free-Standing Homes			
Beechwood/Home	1510 +/-	$266,290	$4,390
Cottonwood/Home	1640 +/-	$299,856	$4,487
Dogwood/Home	1810 +/-	$322,856	$4,615
Elmwood/Home	1940 +/-	$354,459	$4,743

***Standard Entrance Fees amortize by 2% each month for 50 months. Ask about our 50% & 90% Return of Capital Plans.**

Prices pertaining to the cottages and homes reflect a base price per unit. Additional modifications to individual homes may cause these prices to increase. All square footage figures are approximate and designs may vary from drawings.

Effective 10/01/2020©

Residential Living Apartments

Description	Sq. Ft.	*Standard Entrance Fee** 1st person	*Monthly Fee* 1st person
A & B Wings	**Dining Allowance = 2 Meals/day**		
Studio	*230*	20,940	*1,999.00*
Single	*280*	25,490	*2,100.00*
Deluxe Single	*399*	36,319	*2,623.00*
Deluxe Studio	*460*	41,875	*2,775.00*
Combination	*468*	43,183	*2,829.00*
Deluxe Suite	*560*	50,977	*2,982.00*
1 Bedroom Main	*616*	52,799	*3,032.00*
1 Bedroom Suite	*695*	63,268	*3,050.00*
2 Bedroom Suite	*840*	76,467	*3,194.00*
1 Bedroom Grand	*859*	79,217	*3,120.00*
1 Bedroom Den Main	*935*	79,217	*3,194.00*
2 Bedroom Deluxe Suite	*935*	76,467	*3,194.00*
1 Bedroom Flex	*936*	87,131	*3,220.00*
2 Bedroom Main Grand	*1,120*	96,115	*3,341.00*
D Wing	**Dining Allowance - 25 Meals/month**		
One Bedroom	*745*	101,061	*3,051.00*
One Bedroom Deluxe	*826*	106,532	*3,084.00*
Two Bedroom	*1,076*	132,335	*3,465.00*
Two Bedroom Deluxe	*1,322*	153,275	*3,976.00*
Three Bedroom	*1,399*	157,996	*4,230.00*
Three Bedroom Spec/Del	*1,455*	175,405	*4,485.00*
East & West Wings	**Dining Allowance - 25 Meals/month**		
One Bedroom Alcove	*744*	106,985	*3,062.00*
One Bedroom	*805*	113,140	*3,083.00*
One Bedroom Den	*961*	125,008	*3,273.00*
Two Bedroom	*1,090*	144,469	*3,481.00*
Two Bedroom Bay	*1,301*	168,716	*4,229.00*
Two Bedroom Greatroom	*1,513*	190,130	*4,545.00*
Second Person Fee add...		9,281	*1,166.00*

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www.CypressGlen.org

Monthly fee includes:

- -Meal Plan
- -Utilities (electricity, water, sewer, trash)
- -Basic cable television
- -Weekly housekeeping
- -Emergency communications system
- -Local medical appointment transportation
- -Maintenance-free lifestyle
- -Planned activities & trips
- -Wellness center

For Apartments with patios add to entrance fee: $2,441 for Standard Agreement

*The Standard Entrance Fee Plan amortizes at 2% per month for 50 months. After 50 months, there is no refund.

 All rates are reviewed annually /Effective: October 1, 2020

Residential Living Apartments
Guaranteed Refund Entrance Fee Options

Description	Sq. Ft.	Monthly Fee 1st person	50% ROC Entrance Fee* 1st Person	80% ROC Entrance Fee* 1st Person	90% ROC Entrance Fee* 1st Person
Apartments - A & B Wings		**Dining Allowance = 2 Meals/day**			
Studio	230	*1,999.00*	29,316	35,598	40,310
Single	280	*2,100.00*	35,686	43,333	49,068
Deluxe Single	399	*2,623.00*	50,847	61,742	69,914
Deluxe Studio	460	*2,775.00*	58,625	71,188	80,609
Combination	468	*2,829.00*	60,456	73,411	83,127
Deluxe Suite	560	*2,982.00*	71,368	86,661	98,131
1 Bedroom Main	616	*3,032.00*	73,919	89,758	101,638
1 Bedroom Suite	695	*3,050.00*	88,575	107,556	121,791
2 Bedroom Suite	840	*3,194.00*	107,054	129,994	147,199
1 Bedroom Grand	859	*3,120.00*	110,904	134,669	152,493
1 Bedroom Den Main	935	*3,194.00*	110,904	134,669	152,493
2 Bedroom Deluxe Suite	935	*3,194.00*	107,054	129,994	147,199
1 Bedroom Flex	936	*3,220.00*	121,983	148,123	167,727
2 Bedroom Main Grand	1,120	*3,341.00*	134,561	163,396	185,021
Apartments - D Wing		**Dining Allowance - 25 Meals/month**			
One Bedroom	745	*3,051.00*	141,485	171,804	194,542
One Bedroom Deluxe	826	*3,084.00*	149,145	181,104	205,074
Two Bedroom	1,076	*3,465.00*	185,269	224,970	254,745
Two Bedroom Deluxe	1,322	*3,976.00*	214,585	260,568	295,054
Three Bedroom	1,399	*4,230.00*	221,194	268,593	304,142
Three Bedroom Spec/Del	1,455	*4,485.00*	245,567	298,189	337,655
Apartments - East & West Wing		**Dining Allowance - 25 Meals/month**			
One Bedroom Alcove	744	*3,062.00*	149,779	181,875	205,946
One Bedroom	805	*3,083.00*	158,396	192,338	217,795
One Bedroom Den	961	*3,273.00*	175,011	212,514	240,640
Two Bedroom	1,090	*3,481.00*	202,257	245,597	278,103
Two Bedroom Bay	1,301	*4,229.00*	236,202	286,817	324,778
Two Bedroom Greatroom	1,513	*4,545.00*	266,182	323,221	366,000
Second Person Fee add...		***1,166.00***	**12,993**	**15,778**	**17,866**

For Apartments w/patios add to entrance fee: $3,417 for 50% ROC Agreement; $4,150 for 80% ROC Agreement; or $4,699 for 90% ROC Agreement

*The 50% Refund of Capital Plan (ROC) amortizes at 2% per month for 25 months with 50% refunded as outlined in the Residency Agreement.
*The 80% Refund of Capital Plan (ROC) amortizes at 2% per month for 10 months with 80% refunded as outlined in the Residency Agreement.
*The 90% Refund of Capital Plan (ROC) amortizes at 2% per month for 5 months with 90% refunded as outlined in the Residency Agreement.

All rates are reviewed annually /Effective: October 1, 2020

Residential Living Cottages

Styles	Sq. Ft.	Standard EF* 1st person	Monthly Fee 1st person
Dining Allowance = 25 meals/month			
The Dogwood - 1 BR	1,074	135,164	$3,425.00
The Cypress - 2 BR	1,310	170,672	$4,230.00
The Birch - 2 BR	1,437	169,776	$4,420.00
The Alder - 2 BR	1,680	194,292	$4,612.00
The Elm - 2 BR	2,042	229,445	$4,997.00
The Evergreen - 2 BR	2,250+	249,277	$5,464.00
The Willow - 2 BR	2,061	250,578	$5,099.00
Second Person Fee add...		$9,281	$1,166.00

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OR Choose from Guaranteed Refund Entrance Fee Options

Styles	Sq. Ft.	50% ROC EF 1st person	80% ROC EF 1st person	90% ROC EF 1st person	Monthly Fee 1st person
Dining Allowance = 25 meals/month					
The Dogwood - 1 BR	1,074	189,230	229,779	260,191	$3,425.00
The Cypress - 2 BR	1,310	238,941	290,142	328,544	$4,230.00
The Birch - 2 BR	1,437	237,686	288,619	326,819	$4,420.00
The Alder - 2 BR	1,680	272,009	330,296	374,012	$4,612.00
The Elm - 2 BR	2,042	321,223	390,057	441,682	$4,997.00
The Evergreen - 2 BR	2,250+	348,988	423,771	479,858	$5,464.00
The Willow - 2 BR	2,061	350,809	425,983	482,363	$5,099.00
Second Person Fee add...		12,993	15,778	17,866	$1,166.00

*The Standard Entrance Fee Plan amortizes at 2% per month for 50 months. After 50 months, there is no refund.
*The 50% Refund of Capital Plan (ROC) amortizes at 2% per month for 25 months with 50% refunded as outlined in the Residency Agreement.
*The 80% Refund of Capital Plan (ROC) amortizes at 2% per month for 10 months with 80% refunded as outlined in the Residency Agreement.
*The 90% Refund of Capital Plan (ROC) amortizes at 2% per month for 5 months with 90% refunded as outlined in the Residency Agreement.

The Monthly fee inlcudes:
- Meal Plan
- Utilities (heating, cooling, electricity, system water, sewer & trash removal)
-Cable TV
- Weekly housekeeping services
- Emergency communications
- Maintenance-free lifestyle
- Wellness Center

B/2-11

Effective: October 1, 2020

Garden Villas and Cottages

Styles	Sq. Ft.	Standard EF* 1st person	Monthly Fee 1st person
Meal Plan = 25 meals/month			
Hawthorn Villa	1,530	226,287	$3,981.00
Magnolia Villa	1,708	252,613	$4,373.00
Oak Villa	1,865	275,834	$4,717.00
Hawthorn Cottage	1,530	241,893	$3,981.00
Oak Cottage	1,890	298,809	$4,781.00
Second Person Fee add...		$8,921	$1,086.00

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OR Choose from Guaranteed Refund Entrance Fee Options

Styles	Sq. Ft.	50% ROC EF 1st person	80% ROC EF 1st person	90% ROC EF 1st person	Monthly Fee 1st person
Meal Plan = 25 meals/month					
Hawthorn Villa	1,530	316,802	384,688	435,602	$3,981.00
Magnolia Villa	1,708	353,658	429,442	486,280	$4,373.00
Oak Villa	1,865	386,168	468,918	530,980	$4,717.00
Hawthorn Cottage	1,530	338,650	411,218	465,644	$3,981.00
Oak Cottage	1,890	418,333	507,976	575,207	$4,781.00
Second Person Fee add...		12,489	15,166	17,310	$1,086.00

*The Standard Entrance Fee Plan amortizes at 2% per month for 50 months. After 50 months, there is no refund.
*The 50% Refund of Capital Plan (ROC) amortizes at 2% per month for 25 months with 50% refunded as outlined in the Residency Agreement.
*The 80% Refund of Capital Plan (ROC) amortizes at 2% per month for 10 months with 80% refunded as outlined in the Residency Agreement.
*The 90% Refund of Capital Plan (ROC) amortizes at 2% per month for 5 months with 90% refunded as outlined in the Residency Agreement.

The Monthly fee inlcudes:
- Meal Plan
- Utilities (heating, cooling, electricity, water, sewer, trash removal)
-Cable TV
- Weekly housekeeping services
- Emergency communications system
- Maintenance-free lifestyle
- Wellness Center

Effective: October 1, 2020

NC MCC Bond Sale Approval Form

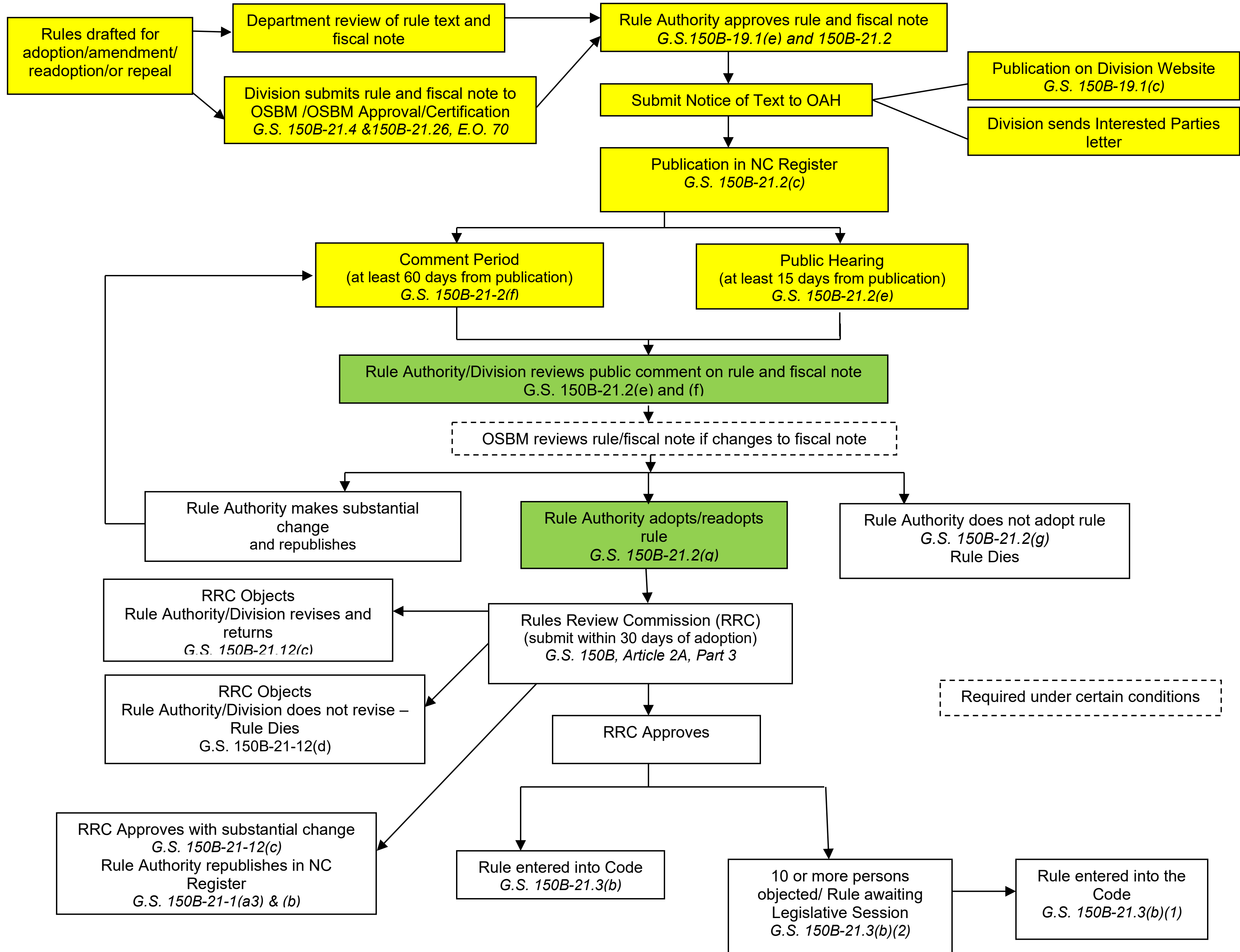
Facility Name: The United Methodist Retirement Homes, Inc.

SERIES:	**Time of Preliminary Approval 2021B**
PAR Amount	$81,175,000
Estimated Interest Rate	2.00%
All-in True Interest Cost	2.09%
Maturity Schedule (Interest) - Date	01/01/22 - 07/06/23
Maturity Schedule (Principal) - Date	01/01/22 - 07/06/23
Bank Holding Period (if applicable) - Date	Full Maturity (07/06/23)
Estimated NPV Savings ($) (if refunded bonds)	See below
Estimated NPV Savings (%) (if refunded bonds)	See below
NOTES:	Will originally be a taxable loan with a forward delivery tax-exempt structure (detailed below) that will take out the 2021B taxable bonds on or about July 6, 2023 when the underlying bonds being refunded become currently callable

SERIES:	**Time of Preliminary Approval 2023**
PAR Amount	$78,140,000
Estimated Interest Rate	2.80%
All-in True Interest Cost	2.90%
Maturity Schedule (Interest) - Date	07/06/23 - 10/01/47
Maturity Schedule (Principal) - Date	07/06/23 - 10/01/47
Bank Holding Period (if applicable) - Date	10/01/36
Estimated NPV Savings ($) (if refunded bonds)	$9,030,579
Estimated NPV Savings (%) (if refunded bonds)	11.72%
NOTES:	This represents the forward delivery tax-exempt bonds that will take out the 2021B taxable bonds on or about July 6, 2023

Process for Medical Care Commission to Adopt/Readopt Rule

Exhibit C



10A NCAC 13F .0405 is readopted as published in 35:24 NCR 2676-2677 as follows:

10A NCAC 13F .0405 QUALIFICATIONS OF FOOD SERVICE SUPERVISOR

~~(a) The~~ Each facility shall have a food service supervisor ~~shall be~~ experienced in food service in commercial or institutional settings ~~and willing to~~ ~~accept consultation from~~ who shall consult with a registered ~~dietitian.~~ dietitian as necessary, to meet the dietary needs of the residents in accordance with Rule .0904 of this Subchapter.

~~(b) Rule 10A NCAC 13G .0405 (c) and (d) shall control for this Subchapter.~~

History Note: *Authority G.S. ~~131D-2.16;~~ 131D-4.5; 131D-2.16; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1987; April 1, ~~1984.~~ 1984;
Readopted Eff. January 1, 2022.

10A NCAC 13F .0509 is amended as published in 35:24 NCR 2676-2677 as follows:

10A NCAC 13F .0509 FOOD SERVICE ORIENTATION

The food service supervisor and adult care home dietary staff ~~person in charge of the preparation and serving of~~ who prepare and serve food shall complete a food service orientation ~~program~~ manual established by the Department or an equivalent within 30 days of ~~hire for those staff hired on or after July 1, 2004.~~ hire. Registered dietitians are exempt from this orientation. The orientation ~~program~~ manual is available on the internet website, ~~http://facility-services.state.nc.us/gcpage.htm, or it is available at the cost of printing and mailing from the Division of Health Service Regulation, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708.~~ https://info.ncdhhs.gov/dhsr/acls/pdf/foodsrvman.pdf, at no cost.

History Note: *Authority G.S. ~~131D-2.16;~~ 131D-4.5; 131D-2.16; 143B-165;*
Temporary Adoption Eff. July 1, 2004;
Temporary Adoption Expired March 12, 2005;
Eff. June 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, ~~2018.~~ 2018;
Amended Eff. January 1, 2022.

10A NCAC 13F .1213 is readopted as published in 35:24 NCR 2676-2677 as follows:

10A NCAC 13F .1213 AVAILABILITY OF CORRECTIVE ACTION AND SURVEY REPORTS

An adult care home shall make available to residents and their families or responsible persons and to prospective residents and their families or responsible persons, upon request and ~~within the facility, corrective action reports by the county departments of social services and facility survey reports by state licensure consultants that have been approved by the Adult Care Licensure Section of the Division of Health Service Regulation within the past 12 months.~~ <u>in a publicly viewable place in the home the following:</u>

<u>(1) the most recent annual or biennial and subsequent facility survey reports issued by the Adult Care Licensure Section of the Division of Health Service Regulation;</u>

<u>(2) any other reports issued by the Adult Care Licensure Section of the Division of Health Service Regulation within the past 12 months; and</u>

<u>(3) corrective action reports issued by the county department of social services within the past 12 months.</u>

History Note: *Authority G.S. 131D-2.16; 143-165;*
Eff. July 1, ~~2005.~~ <u>2005;</u>
<u>Readopted Eff. January 1, 2022.</u>

10A NCAC 13G .0509 is readopted as published in 35:24 NCR 2676-2677 as follows:

10A NCAC 13G .0509 FOOD SERVICE ORIENTATION

~~The family~~ Family care home staff ~~person in charge of the preparation and serving of~~ who prepare and serve food shall complete a food service orientation ~~program~~ manual established by the Department or an equivalent within 30 days of ~~hire for those staff hired on or after July 1, 2004.~~ hire. The orientation ~~program~~ manual is available on the internet website, ~~http://facility-services.state.nc.us/gcpage.htm, or it is available at the cost of printing and mailing from the Division of Health Service Regulation, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708.~~ https://info.ncdhhs.gov/dhsr/acls/pdf/foodsrvman.pdf, at no cost.

History Note: *Authority G.S. ~~131D-2.16;~~ 131D-4.5; 131D-2.16; 143B-165;*
Temporary Adoption Eff. July 1, 2004;
Temporary Adoption Expired March 12, 2005;
Eff. June 1, ~~2005.~~ 2005;
Readopted Eff. January 1, 2022.

10A NCAC 13G .1214 is readopted as published in 35:24 NCR 2676-2677 as follows:

10A NCAC 13G .1214 AVAILABILITY OF CORRECTIVE ACTION AND SURVEY REPORTS

A family care home shall make available ~~within the facility, upon request, corrective action reports by the county departments of social services and facility survey reports by state licensure consultants that have been approved by the Adult Care Licensure Section of the Division of Health Service Regulation within the past 12 months to residents and their families or responsible persons and to prospective residents and their families or responsible persons.~~ to residents and their families or responsible persons and to prospective residents and their families or responsible persons, upon request and in a publicly viewable place in the home the following:

(1) the most recent annual or biennial and subsequent facility survey reports issued by the Adult Care Licensure Section of the Division of Health Service Regulation;

(2) any other survey reports issued by the Adult Care Licensure Section of the Division of Health Service Regulation within the past 12 months; and

(3) corrective action reports issued by the county department of social services within the past 12 months.

History Note: *Authority 131D-2.16; 143B-165;*
Eff. July 1, ~~2005.~~ 2005;
Readopted Eff. January 1, 2022.

DHSR Adult Care Licensure Section
Fiscal Impact Analysis
Permanent Rule Readoption and Amendment without Substantial Economic Impact

Agency: North Carolina Medical Care Commission

Contact Persons: Nadine Pfeiffer, DHSR Rules Review Manager, (919) 855-3811
Megan Lamphere, Adult Care Licensure Section Chief, (919) 855-3784
Tichina Hamer, Director of Programs, (919) 855-3782

Impact:

Federal Government: No
State Government: No
Local Government: No
Private Entities: Yes
Substantial Impact: No

Titles of Rule Changes and N.C. Administrative Code Citation

Rule Readoptions (*See proposed text of these rules in Appendix)*
10A NCAC 13F .0405 Qualifications of Food Service Supervisor
10A NCAC 13F .1213 Availability of Corrective Action and Survey Reports
10A NCAC 13G .0509 Food Service Orientation
10A NCAC 13G .1214 Availability of Corrective Action and Survey Reports

Rule Amendment (*See proposed text of these rules in Appendix)*
10A NCAC 13F .0509 Food Service Orientation

Authorizing Statutes: G.S. 131D-2.16; 131D-4.5; 143B-165

Introduction and Background

The Adult Care Licensure Section is proposing changes to clarify the experience needed for Food Service Supervisors in adult care homes and further clarify when a food service supervisor should consult with a dietitian. Additional technical changes clarify staff who are required to complete the food service manual. Technical changes to the rules update them to current standards according to statute and provide clarity to the types of reports providers should make available to residents, residents' families and other responsible persons. The technical changes are proposed for clarity and consistency but do not affect current operations. The proposed changes will have limited fiscal impact on adult care homes and family care homes as they are privately owned and are mostly in line with current practice based on recent surveys. The proposed changes will have no fiscal impact on the Adult Care Licensure Section.

Under the authority of G.S. 150B-21.3A, Periodic review of existing rules, the North Carolina Medical Care Commission and Rule Review Commission approved the Subchapter reports with classifications for the rules under 10A NCAC 13F Licensing of Adult Care Homes of Seven or More

Beds and 10 NCAC 13G Licensing of Family Care Homes. The rules were classified in the reports as necessary with substantive public interest. Rules 10A NCAC 13G .0509, 13G .1214 and 13F .0405 and 13F .1213 are being presented for readoption with substantive changes. The following rule was not identified for readoption with substantive changes based on public comment but is being proposed for amendment to correlate with the 13G rule of the same title and similar content being proposed for readoption: 10A NCAC 13F .0509. Most of the rules for both types of assisted living residences, adult care homes of seven beds or more and family care homes, are the same with the primary exception of staffing and physical plant requirements since they serve the same population based on need for care and services. Therefore, the 13F rules corresponding to the 13G rules being proposed for readoption with substantive changes are being amended concurrently to assure this traditional consistency. The rule proposed for amendment, while not receiving comment for substantive change, is being amended for clarification and updating purposes.

Rules Summary and Anticipated Fiscal Impact

10A NCAC 13F .0405 Qualifications of Food Service Supervisor: Technical changes were made to this rule to provide clarification on the experience of a food service supervisor and when to consult with a dietitian. Revisions to this rule also includes the deletion 13F .0405 (b) due to the reference to rules 10A NCAC 13G .0405 (c) and (d) no longer exist.

1. The rule as written requires food service supervisors to have experience in food service. The proposed rule language allows providers the opportunity to implement their hiring practices and employ food service supervisors based on the experience the provider determines will best meets the dietary needs of the residents and duties assigned as an employee of the facility.

Rationale: In a recent survey conducted by ACLS in January 2021 of adult care providers, 67% percent of providers reported hiring food service supervisors with at least one year of experience in food service and experience as a food service supervisor. The survey revealed while 26% of providers sought restaurant experience, 41% of experiences include working at other adult care and long-term care facilities, cafeterias, hospitals, resorts, culinary school, and as a certified dietary manager. This experience is consistent with the proposed language to reflect experience in commercial or institutional settings. The survey revealed providers promote dietary staff into the role of food service supervisor. Although food service supervisors have experience from varied food service roles, they are required to complete the additional training of the food service orientation manual in accordance with 13F .0509.

Fiscal Impact: There is no fiscal impact since the rule language was updated to reflect providers' current standards for hiring food service supervisors.

2. The current rule as written directs food service supervisors be willing to accept consultation from a dietitian. The proposed rule modifies the language to reflect the intent of the rule which directs food service supervisors to consult with a dietitian when there is an identified need for assistance related to rule 13F .0904.

Rationale: Adult Care providers establish the types of therapeutic diets they are able to prepare and serve to residents based on dietitian-approved therapeutic menus. The menus serve as guides to the unlicensed dietary staff on what to prepare and how to prepare food items for individuals with therapeutic diets.
The need for consultation is primarily associated with therapeutic diets. Therapeutic diets provide limitations or modifies "the intake of certain foods or nutrients. It is part of the treatment of a medical

condition and are normally prescribed by a physician and planned by a dietician. A therapeutic diet is usually a modification of a regular diet. In therapeutics diets, modifications are done in nutrients, texture and food allergies or food intolerances" (Journal of Clinical Nutrition & Dietetics, 2021). Food Service Supervisors are required to have experience in settings where food is prepared for a variety of individuals and where foods prepared are based on therapeutic menus approved by dietitians. Adult Care facilities are not required to employ registered dietitians as part of their daily operations. In accordance with rule 10A NCAC 13F .0904(c)(6), therapeutic menus are to be planned or reviewed by registered dietitian.

Facilities are required to provide nutrition to residents based on daily food requirements as outlined in 10A NCAC 13F .0904(d). Residents without nutritional restrictions are considered on a regular diet. Any physician-ordered modification to residents' nutritional intake, such as diet type, requires a therapeutic menu approved by a dietitian to provide guidance to the facility's dietary staff as what foods to prepare and how to prepare food modification. Examples of therapeutic diets ordered by physicians include "No Concentrated Sweets" to reduce sugar intake for residents diagnosed with diabetes or "No Added Salt" to reduce sodium for hypertension. As a resident's medical or nutritional needs change, a physician may order a therapeutic diet to address the resident's need. A consultation with the dietitian may be needed when there is not an approved therapeutic diet to match the order. Providers may notify the physician of the types of therapeutic menus already approved by the dietitian and request the physician clarify the order by ordering the use of an existing therapeutic menu. A consultation with a dietitian may be needed to provide guidance to food service supervisors when ordered to change the texture of food or liquids or managing food preferences of newly admitted residents.

Fiscal Impact: There is no fiscal impact since consultation with a dietitian is required based on current rules. There is limited data on the frequency of dietary consultations required; however, dietitian hourly rate is approximately $30/hour in North Carolina[1].

10A NCAC 13F .0509 & 13G .0509 Food Service Orientation: Technical changes were made to this rule to clarify the type of food service orientation training, who is required to complete the training and how to obtain copies of the training.

1. Both 13F .0509 and 13G .0509 requires food service staff to complete the orientation manual. Technical changes to the rule clarifies the staff required to complete the food service orientation manual.

Rationale: In family care homes, due to the size of the facility with a maximum capacity of 6 residents, there is primarily one staff preparing each meal. Unlike adult care facilities, due to the resident capacity, multiple food service staff are required to prepare and serve food to ensure the food service standards are met. In a December 2020 survey, adult care facilities reported, 55% employ between 1-5 food service staff.

Table 1: December 2020 ACLS Survey, Number of Food Service Staff at Adult Care Facilities

Number of Food Service Staff	Percentage of Adult Care Facilities
1-5 employees	55%
6-10 employees	35%
11-15 employees	6%
16-20 employees	2%
21 or more employees	2%

[1] (U.S. Bureau of Labor Statistics, 2019)

In the December 2020 survey, 61% of adult care facilities reported that all of their food service staff completed the food service orientation manual, while an additional 31% of facilities reported all food service staff, personal care aides and medication aides that are involved in serving food.

2. Technical changes were made to the rule to clarify the wording the required training for food service staff. The language as currently written refers to the required training as a food service "orientation program". The proposed language was modified to reflect the name of the training which is food service "orientation manual". The orientation manual includes a quiz for food service staff based on the information presented in the manual.

3. The rule as written provides a mailing address for copies of the Food Service Orientation manual. The proposed language removes the mailing address and provides an updated internet address where the orientation manual is available at no cost.

Fiscal Impact: There are no fiscal impacts to providers for the technical changes made to these rules.

10A NCAC 13F .1213 & 13G .1214 Availability of Corrective Action and Survey Reports: Technical changes were made to this rule to clarify the length of time survey reports and corrective action reports are to remain available at the facility for review by residents, residents' family members and responsible persons.

Rationale: The Adult Care Licensure Section and local County Department of Social Services (DSS) are mandated to by N.C. Gen. Stat. §131D-2.11 to inspect and monitor facilities for regulatory compliance. Types of inspections conducted by ACLS at facilities include annual or biennial surveys and follow up or subsequent surveys related to identified deficient practice and complaint investigations. Local County DSS conduct quarterly routine monitoring and complaint investigations. Providers receive written reports for all ACLS inspections and Corrective Action Reports issued by local County DSS that result in noncompliance with rules.

N.C. Gen. Stat. §131D-2.11 outlines the frequency of inspections by ACLS based on facility's rating effective in the year 2007. The facility's rating determines if ACLS inspections of the facility will be annual or biennial. The rule as currently written does account for the statute including biennial inspections. The proposed rule language clarifies the type of survey reports required to be available to residents, residents' family members and responsible persons. The proposed rule clarifies available to include within public view. The proposed rule updates the survey frequency to be consistent with the statute.

Fiscal Impact: There is no fiscal impact as providers were previously required to make these reports available. There is limited to no cost to provide the reports as these reports are mailed or hand-delivered to the facility.

10A NCAC 13F .0405 is proposed for readoption with substantive changes as follows:

10A NCAC 13F .0405 QUALIFICATIONS OF FOOD SERVICE SUPERVISOR

~~(a) The~~ Each facility shall have a food service supervisor ~~shall be~~ experienced in food service in commercial or institutional settings ~~and willing to~~ ~~accept consultation from~~ who shall consult with a registered ~~dietitian.~~ dietitian as necessary, to meet the dietary needs of the residents in accordance with Rule .0904 of this Subchapter.

~~(b) Rule 10A NCAC 13G .0405 (c) and (d) shall control for this Subchapter.~~

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Amended Eff. April 1, 1987; April 1, ~~1984.~~ 1984;
Readopted Eff. January 1, 2022.

10A NCAC 13F .0509 is proposed for amendment as follows:

10A NCAC 13F .0509 FOOD SERVICE ORIENTATION

The food service supervisor and adult care home dietary staff ~~person in charge of the preparation and serving of~~ who prepare and serve food shall complete a food service orientation ~~program~~ manual established by the Department or an equivalent within 30 days of ~~hire for those staff hired on or after July 1, 2004.~~ hire. Registered dietitians are exempt from this orientation. The orientation ~~program~~ manual is available on the internet website, ~~http://facility-services.state.nc.us/gcpage.htm, or it is available at the cost of printing and mailing from the Division of Health Service Regulation, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708.~~ https://info.ncdhhs.gov/dhsr/acls/pdf/foodsrvman.pdf, at no cost.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. July 1, 2004;
Temporary Adoption Expired March 12, 2005;
Eff. June 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 6, ~~2018.~~ 2018;
Amended Eff. January 1, 2022.

10A NCAC 13F .1213 is proposed for readoption with substantive changes as follows:

10A NCAC 13F .1213 AVAILABILITY OF CORRECTIVE ACTION AND SURVEY REPORTS

An adult care home shall make available to residents and their families or responsible persons and to prospective residents and their families or responsible persons, upon request and ~~within the facility, corrective action reports by the county departments of social services and facility survey reports by state licensure consultants that have been approved by the Adult Care Licensure Section of the Division of Health Service Regulation within the past 12 months.~~ in a publicly viewable place in the home the following:

(1) the most recent annual or biennial and subsequent facility survey reports issued by the Adult Care Licensure Section of the Division of Health Service Regulation;

(2) any other reports issued by the Adult Care Licensure Section of the Division of Health Service Regulation within the past 12 months; and

(3) corrective action reports issued by the county department of social services within the past 12 months.

History Note: *Authority G.S. 131D-2.16; 143-165;*
Eff. July 1, ~~2005.~~ 2005;
Readopted Eff. January 1, 2022.

10A NCAC 13G .0509 is proposed for readoption without substantive changes as follows:

10A NCAC 13G .0509 FOOD SERVICE ORIENTATION

~~The family~~ Family care home staff ~~person in charge of the preparation and serving of~~ who prepare and serve food shall complete a food service orientation ~~program~~ manual established by the Department or an equivalent within 30 days of ~~hire for those staff hired on or after July 1, 2004.~~ hire. The orientation ~~program~~ manual is available on the internet website, ~~http://facility-services.state.nc.us/gcpage.htm, or it is available at the cost of printing and mailing from the Division of Health Service Regulation, Adult Care Licensure Section, 2708 Mail Service Center, Raleigh, NC 27699-2708.~~ https://info.ncdhhs.gov/dhsr/acls/pdf/foodsrvman.pdf, at no cost.

History Note: *Authority G.S. 131D-2.16; 131D-4.5; 143B-165;*
Temporary Adoption Eff. July 1, 2004;
Temporary Adoption Expired March 12, 2005;
Eff. June 1, ~~2005.~~ 2005;
Readopted Eff. January 1, 2022.

10A NCAC 13G .1214 is proposed for readoption with substantive changes as follows:

10A NCAC 13G .1214 AVAILABILITY OF CORRECTIVE ACTION AND SURVEY REPORTS

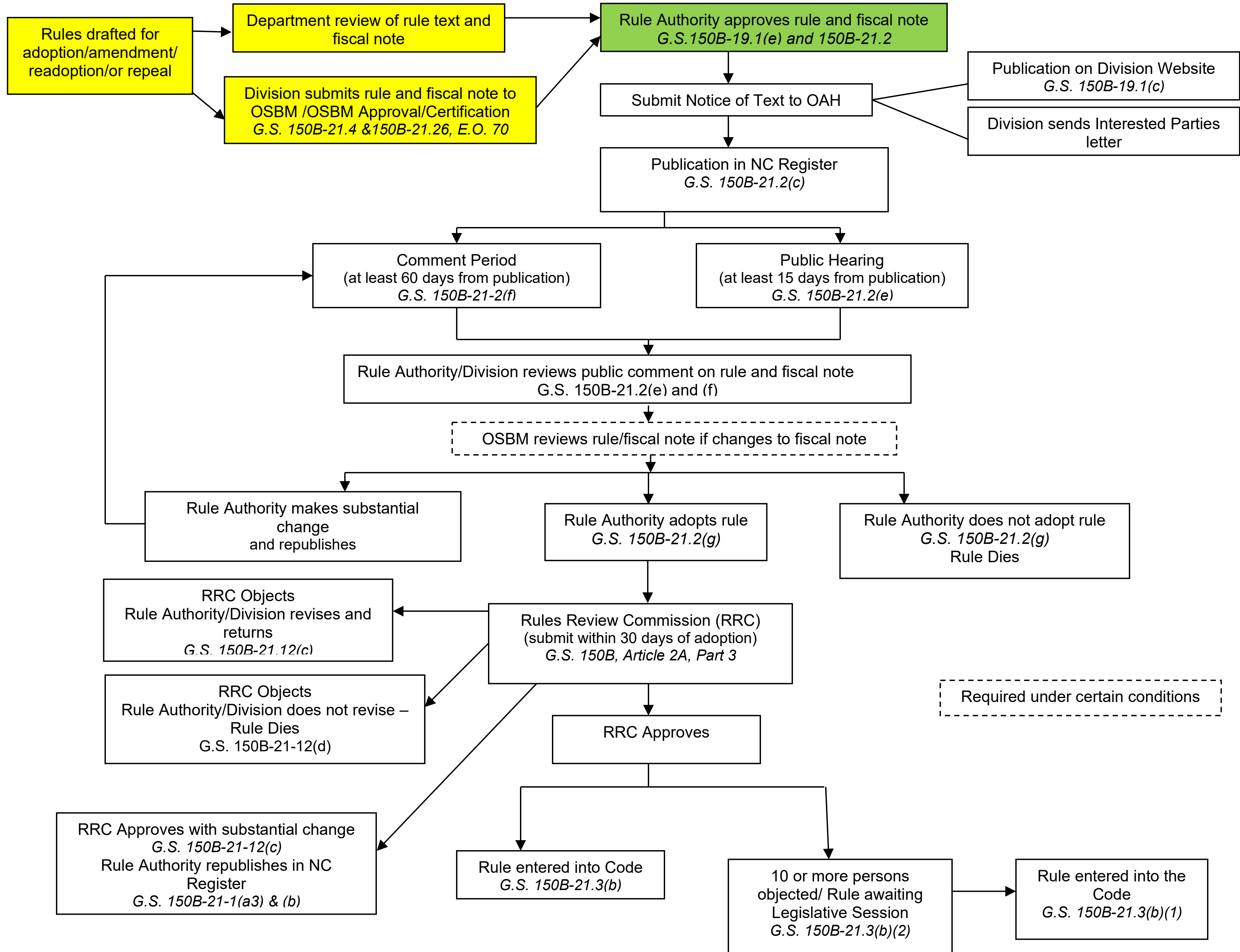
A family care home shall make available ~~within the facility, upon request, corrective action reports by the county departments of social services and facility survey reports by state licensure consultants that have been approved by the Adult Care Licensure Section of the Division of Health Service Regulation within the past 12 months to residents and their families or responsible persons and to prospective residents and their families or responsible persons.~~ to residents and their families or responsible persons and to prospective residents and their families or responsible persons, upon request and in a publicly viewable place in the home the following:

(1) the most recent annual or biennial and subsequent facility survey reports issued by the Adult Care Licensure Section of the Division of Health Service Regulation;

(2) any other survey reports issued by the Adult Care Licensure Section of the Division of Health Service Regulation within the past 12 months; and

(3) corrective action reports issued by the county department of social services within the past 12 months.

History Note: *Authority 131D-2.16; 143B-165;*
Eff. July 1, ~~2005.~~ 2005;
Readopted Eff. January 1, 2022.


Process for Medical Care Commission to Initiate Rulemaking
Exhibit D
Rules drafted for adoption/amendment/ readoption/or repeal
Department review of rule text and fiscal note
Division submits rule and fiscal note to OSBM /OSBM Approval/Certification
G.S. 150B-21.4 &150B-21.26, E.O. 70
Rule Authority approves rule and fiscal note
G.S.150B-19.1(e) and 150B-21.2
Submit Notice of Text to OAH
Publication on Division Website
G.S. 150B-19.1(c)
Division sends Interested Parties letter
Publication in NC Register
G.S. 150B-21.2(c)
Comment Period
(at least 60 days from publication)
G.S. 150B-21-2(f)
Public Hearing
(at least 15 days from publication)
G.S. 150B-21.2(e)
Rule Authority/Division reviews public comment on rule and fiscal note
G.S. 150B-21.2(e) and (f)
OSBM reviews rule/fiscal note if changes to fiscal note
Rule Authority makes substantial change and republishes
Rule Authority adopts rule
G.S. 150B-21.2(g)
Rule Authority does not adopt rule
G.S. 150B-21.2(g)
Rule Dies
RRC Objects
Rule Authority/Division revises and returns
G.S. 150B-21.12(c)
Rules Review Commission (RRC)
(submit within 30 days of adoption)
G.S. 150B, Article 2A, Part 3
RRC Objects
Rule Authority/Division does not revise – Rule Dies
G.S. 150B-21-12(d)
RRC Approves
Required under certain conditions
RRC Approves with substantial change
G.S. 150B-21-12(c)
Rule Authority republishes in NC Register
G.S. 150B-21-1(a3) & (b)
Rule entered into Code
G.S. 150B-21.3(b)
10 or more persons objected/ Rule awaiting Legislative Session
G.S. 150B-21.3(b)(2)
Rule entered into the Code
G.S. 150B-21.3(b)(1)

10A NCAC 13B .3801 is proposed for readoption with substantive changes as follows:

SECTION .3800 - NURSING SERVICES

10A NCAC 13B .3801 NURSE EXECUTIVE

(a) Whether the facility utilizes a centralized or decentralized organizational structure, a nurse executive shall be responsible for the coordination of nursing organizational functions.

(b) A nurse executive shall develop facility wide patient care programs, ~~policies~~ policies, and procedures that describe how the nursing care needs of patients are assessed, ~~met~~ met, and evaluated.

(c) The nurse executive shall develop and adopt, subject to the approval of the facility, a set of administrative policies and procedures to establish a framework to accomplish required functions.

(d) There shall be scheduled ~~meetings,~~ meetings ~~at least~~ every 60 ~~days,~~ days of the members of the nursing staff to evaluate the quality and efficiency of nursing services. Minutes of these meetings shall be maintained.

(e) The nurse executive shall be responsible for:

(1) the development of a written organizational plan which describes the levels of accountability and responsibility within the nursing organization;

(2) identification of standards and policies and procedures related to the delivery of nursing care;

(3) planning for and the evaluation of the delivery of nursing care delivery system;

(4) establishment of a mechanism to validate qualifications, knowledge, and skills of nursing personnel;

(5) provision of orientation and educational opportunities related to expected nursing ~~performance,~~ performance and maintenance of records pertaining thereto;

(6) implementation of a system for performance evaluation;

(7) provision of nursing care services in conformance with ~~the North Carolina Nursing Practice Act;~~ G.S. 90-171.20(7) and G.S. 90-171.20(8);

(8) assignment of nursing staff to clinical or managerial responsibilities based upon educational preparation, in conformance with licensing laws and an assessment of current competence; and

(9) staffing nursing units with ~~sufficient~~ personnel in accordance with a written ~~plan.~~ plan of care to meet the needs of the patients.

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .3903 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .3903 PRESERVATION OF MEDICAL RECORDS

(a) The manager of medical records service shall maintain medical records, whether original, computer media, or microfilm, for ~~a minimum of~~ 11 years following the discharge of an adult patient.

(b) The manager of medical records shall maintain medical records of a patient who is a minor until the patient's 30th birthday.

(c) If a hospital discontinues operation, its management shall make known to the Division where its records are stored. Records shall be stored in a business offering retrieval services for ~~at least~~ 11 years after the closure date.

~~(d) The hospital shall give public notice prior to destruction of its records, to permit former patients or representatives of former patients to claim the record of the former patient. Public notice shall be in at least two forms: written notice to the former patient or their representative and display of an advertisement in a newspaper of general circulation in the area of the facility.~~

~~(e)~~ (d) The manager of medical records may authorize the microfilming of medical records. Microfilming may be done on or off the premises. If done off the premises, the facility shall provide for the confidentiality and safekeeping of the records. The original of microfilmed medical records shall not be destroyed until the medical records department has had an opportunity to review the processed film for content.

~~(f)~~ (e) Nothing in this Section shall be construed to prohibit the use of automation in the medical records service, provided that all of the provisions in this Rule are met and the information is readily available for use in patient care.

~~(g)~~ (f) Only personnel authorized by ~~state~~ State laws and Health Insurance Portability and Accountability Act (HIPAA) regulations shall have access to medical records. Where the written authorization of a patient is required for the release or disclosure of health information, the written authorization of the patient or authorized representative shall be maintained in the original record as authority for the release or disclosure.

~~(h)~~ (g) Medical records are the property of the hospital, and they shall not be removed from the facility jurisdiction except through a court order. Copies shall be made available for authorized purposes such as insurance claims and physician review.

History Note: *Authority G.S. ~~90-21.20B;~~ 131E-75(b); 131E-79; 131E-97;*
Eff. January 1, 1996;
Amended Eff. July 1, ~~2009.~~ 2009;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4103 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .4103 PROVISION OF EMERGENCY SERVICES

(a) Any ~~of any~~ facility providing emergency services shall establish and maintain policies requiring ~~appropriate~~ medical screening, treatment and transfer services for any individual who presents to the facility emergency department and on whose behalf treatment is requested regardless of that person's ability to pay for medical services and without delay to inquire about the individual's method of payment.

(b) Any facility providing emergency services under the rules of this Section shall install, ~~operate~~ operate, and maintain, on a 24-hour per day basis, an emergency two-way radio ~~licensed by the Federal Communications Commission in the Public Safety Radio Service~~ capable of ~~establishing~~ accessing the North Carolina Voice Interoperability Plan for Emergency Responders (VIPER) radio network for voice ~~radio~~ communication with ~~ambulance units~~ EMS providers transporting patients to ~~said~~ the facility or ~~having any written procedure or agreement for handling emergency services with the local ambulance service, rescue squad or other trained medical~~ or provide on-line medical direction for EMS personnel.

(c) All communication equipment shall be in compliance with ~~current~~ the rules ~~established by North Carolina Rules for Basic Life Support/Ambulance Service (10 NCAC 3D .1100) adopted by reference with all subsequent amendments. Referenced rules are available at no charge from the Office of Emergency Medical Services, 2707 Mail Service Center, Raleigh, N.C. 27699-2707.~~ set forth in 10A NCAC 13P, Emergency Medical Services and Trauma Rules.

History Note: Authority G.S. 131E-75(b); 131E-79;
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4104 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .4104 MEDICAL DIRECTOR

(a) The governing body shall establish the qualifications, duties, and authority of the director of emergency services. Appointments shall be recommended by the medical staff and approved by the governing body.

(b) The medical staff credentials committee shall approve the mechanism for emergency privileges for physicians employed for brief periods of time such as evenings, ~~weekends~~ weekends, or holidays.

(c) Level I and II emergency services shall be directed and supervised by a ~~physician with experience in emergency care.~~ physician.

(d) Level III services shall be directed and supervised by a ~~physician with experience in emergency care or through a multi-disciplinary medical staff committee. The chairman of this committee shall serve as director of emergency medical services.~~ physician.

History Note: *Authority G.S. 131E-75(b); 131E-79; 131E-85(a);*
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4106 is proposed for readoption without substantive changes as follows:

10A NCAC 13B .4106 POLICIES AND PROCEDURES

Each emergency department shall establish written policies and procedures ~~which~~ that specify the scope and conduct of patient care to be provided in the emergency areas. They shall include the following:

(1) the location, storage, and procurement of medications, blood, supplies, equipment and the procedures to be followed in the event of equipment failure;

(2) the initial management of patients with burns, hand injuries, head injuries, fractures, multiple injuries, poisoning, animal bites, gunshot or stab ~~wounds~~ wounds, and other acute problems;

(3) the provision of care to an unemancipated minor not accompanied by a parent or guardian, or to an unaccompanied unconscious patient;

(4) management of alleged or suspected child, ~~elder~~ elder, or adult abuse;

(5) the management of pediatric emergencies;

(6) the initial management of patients with actual or suspected exposure to radiation;

(7) management of alleged or suspected rape victims;

(8) the reporting of individuals dead on arrival to the proper authorities;

(9) the use of standing orders;

(10) tetanus and rabies prevention or prophylaxis; and

(11) the dispensing of medications in accordance with ~~state~~ State and federal laws.

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4305 is proposed for readoption without substantive changes as follows:

10A NCAC 13B .4305 ORGANIZATION OF NEONATAL SERVICES

(a) The governing body shall approve the scope of all neonatal services and the facility shall classify its capability in providing a range of neonatal services using the following criteria:

(1) LEVEL I: Full-term and pre-term neonates that are stable without complications. This may ~~include,~~ include infants who are small for gestational age or large for gestational age neonates.

(2) LEVEL II: Neonates or infants that are stable without complications but require special care and frequent feedings; infants of any weight who no longer require Level III or LEVEL IV neonatal services, but who still require more nursing hours than normal infant. This may include infants who require close observation in a licensed acute care ~~bed~~ bed.

(3) LEVEL III: Neonates or infants that are high-risk, small (or approximately 32 and less than 36 completed weeks of gestational age) but otherwise healthy, or sick with a moderate degree of illness that are admitted from within the hospital or transferred from another facility requiring intermediate care services for sick infants, but not requiring intensive care. The beds in this level may serve as a "step-down" unit from Level IV. Level III neonates or infants require less constant nursing care, but care does not exclude respiratory support.

(4) LEVEL IV (Neonatal Intensive Care Services): High-risk, medically unstable or critically ill neonates approximately under 32 weeks of gestational age, or infants, requiring constant nursing care or supervision ~~not limited to~~ that includes continuous cardiopulmonary or respiratory support, complicated surgical procedures, or other intensive supportive interventions.

(b) The facility shall provide for the availability of equipment, supplies, and clinical support services.

(c) The medical and nursing staff shall develop and approve policies and procedures for the provision of all neonatal services.

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. January 1, 1996;
Temporary Amendment Eff. March 15, 2002;
Amended Eff. April 1, ~~2003.~~ 2003;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4603 is proposed for readoption without substantive changes as follows:

10A NCAC 13B .4603 SURGICAL AND ANESTHESIA STAFF

~~(a)~~ The facility shall develop processes ~~which require that~~ that require each individual ~~provides~~ provide only those services for which proof of licensure and competency can be demonstrated. The facility shall require that:

~~(b) The facility shall require that:~~

(1) when anesthesia is administered, a ~~qualified~~ physician is ~~immediately~~ available in the facility to provide care in the event of a medical emergency;

(2) a roster of practitioners with a delineation of current surgical and anesthesia privileges is available and maintained for the service;

(3) an on-call schedule of surgeons with privileges to be available at all times for emergency surgery and for post-operative clinical management is maintained;

(4) the operating room is supervised by a ~~qualified~~ registered nurse or doctor of medicine or osteopathy; and

(5) an operating room register which shall include date of the operation, name and patient identification number, names of surgeons and surgical assistants, name of anesthetists, type of anesthesia given, pre- and post-operative diagnosis, type and duration of surgical procedure, and the presence or absence of complications in surgery is maintained.

History Note: *Authority G.S. 131E-75(b); 131E-79; 131E-85;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4801 is proposed for readoption without substantive changes as follows:

SECTION .4800 - DIAGNOSTIC IMAGING

10A NCAC 13B .4801 ORGANIZATION

(a) Imaging services shall be under the supervision of a full-time radiologist, consulting radiologist, or a ~~physician~~ physician. ~~experienced in the particular imaging modality and the~~ The physician in charge ~~must~~ shall have the credentials required by facility policies.

(b) ~~Activities of the imaging service may include radio-therapy.~~ Radio-therapy is a type of imaging service.

(c) All imaging equipment shall be operated under professional supervision by ~~qualified~~ personnel trained in the use of imaging equipment and knowledgeable of all applicable safety precautions required by the North Carolina Department of ~~Environment and Natural Resources,~~ Health and Human Services, Division of ~~Environmental~~ Health Service Regulation, Radiation Protection ~~Section.~~ Section set forth in 10A NCAC 15, hereby incorporated by reference including subsequent amendments. ~~Copies of regulations are available from the N.C. Department of Environment and Natural Resources, Radiation Protection Section, 3825 Barrett Drive, Raleigh, NC 27609 at a cost of sixteen dollars ($16.00) each~~.

History Note: *Authority G.S. 131E-75(b); 131E-79;*
RRC objection due to lack of statutory authority and ambiguity Eff. July 13, 1995;
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4805 is proposed for readoption without substantive changes as follows:

10A NCAC 13B .4805 SAFETY

(a) The facility shall require that all imaging equipment is operated under the supervision of a physician and by qualified personnel.

(b) The facility shall require that proper caution is exercised to protect all persons from exposure to radiation.

(c) Safety inspections of the imaging department, including equipment, shall be conducted by the North Carolina Division of ~~Environmental Health,~~ Health Service Regulation, Radiation Protection ~~Services~~ Section. Copies of the report shall be available for review by the Division.

(d) The governing authority shall appoint a radiation safety committee. The committee shall ~~include but is not limited to:~~ include:

(1) a physician experienced in the handling of radio-active isotopes and their therapeutic use; and

(2) other representatives of the medical staff.

(e) All radio-active isotopes, whether for diagnostic, therapeutic, or research purposes shall be received, handled, and disposed of in accordance with the requirements of the North Carolina Department of ~~Environment and Natural Resources,~~ Health and Human Services, Division of ~~Environmental Health,~~ Health Service Regulation, Radiation Protection ~~Services Section.~~ Section set forth in 10A NCAC 15, hereby incorporated by reference including subsequent amendments. ~~Copies of regulations are available from the North Carolina Department of Environment, Health, and Natural Resources, Division of Radiation Protection, 3825 Barrett Drive, Raleigh, NC 27609 at a cost of six dollars ($6.00) each.~~

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .5102 is proposed for readoption without substantive changes as follows:

10A NCAC 13B .5102 POLICY AND PROCEDURES

(a) Each facility department or service shall establish and maintain written infection control policies and procedures. These shall ~~include but are not limited to:~~ include:

(1) the role and scope of the service or department in the infection control program;
(2) the role and scope of surveillance activities in the infection control program;
(3) the methodology used to collect and analyze data, maintain a surveillance program on nosocomial infection, and the control and prevention of infection;
(4) the specific precautions to be used to prevent the transmission of infection and isolation methods to be utilized;
(5) the method of sterilization and storage of equipment and supplies, including the reprocessing of disposable items;
(6) the cleaning of patient care areas and equipment;
(7) the cleaning of non-patient care areas; and
(8) exposure control plans.

(b) The infection control committee shall approve all infection control policies and procedures. The committee shall review all policies and procedures ~~at least~~ every three years and indicate the last date of review.

(c) The infection control committee shall meet ~~at least~~ quarterly and maintain minutes of meetings.

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff July 1, 2022.

1 10A NCAC 13B .5105 is proposed for readoption without substantive changes as follows:
2
3 **10A NCAC 13B .5105 STERILE SUPPLY SERVICES**
4 The facility shall provide for the following:
5 (1) decontamination and sterilization of equipment and supplies;
6 (2) monitoring of sterilizing equipment on a routine schedule;
7 (3) establishment of policies and procedures for the use of disposable items; and
8 (4) establishment of policies and procedures addressing shelf life of stored sterile items.
9
10 *History Note: Authority G.S. 131E-75(b); 131E-79;*
11 *Eff. January 1, ~~1996.~~ 1996;*
12 *Readopted Eff. July 1, 2022.*

10A NCAC 13B .5406 is proposed for readoption without substantive changes as follows:

10A NCAC 13B .5406 DISCHARGE CRITERIA FOR INPATIENT REHABILITATION FACILITIES OR UNITS

(a) Discharge planning shall be an integral part of the patient's treatment plan and shall begin upon admission to the facility. After established goals have been reached, or a determination has been made that care in a less intensive setting would be appropriate, or that further progress is unlikely, the patient shall be discharged to an appropriate setting. Other reasons for discharge may include an inability or unwillingness of patient or family to cooperate with the planned therapeutic program or medical complications that preclude a further intensive rehabilitative effort. The facility shall involve the patient, family, staff ~~members~~ members, and referral sources in discharge planning.

(b) The case manager shall facilitate the discharge or transfer process in coordination with the facility social worker.

(c) If a patient is being referred to another facility for further care, ~~appropriate~~ documentation of the patient's current status shall be forwarded with the patient. A ~~formal~~ discharge summary shall be forwarded within 48 hours following discharge and shall include the reasons for referral, the diagnosis, functional limitations, services provided, the results of services, referral action ~~recommendations~~ recommendations, and activities and procedures used by the patient to maintain and improve functioning.

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. March 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .5408 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .5408 COMPREHENSIVE INPATIENT REHABILITATION PROGRAM STAFFING REQUIREMENTS

(a) The staff of the inpatient rehabilitation facility or unit shall ~~include at a minimum:~~ include:

(1) the inpatient rehabilitation facility or unit shall be supervised by a rehabilitation ~~nurse.~~ nurse as defined in Rule .5401 of this Section. The facility shall ~~identify the nursing skills necessary to meet the needs of the rehabilitation patients in the unit and~~ assign staff qualified to meet those needs;

(2) the minimum nursing hours per patient in the rehabilitation unit shall be 5.5 nursing hours per patient day. At no time shall direct care nursing staff be less than two full-time equivalents, one of which must be a registered nurse;

(3) the inpatient rehabilitation unit shall employ or provide by contractual agreements ~~sufficient~~ therapist to provide ~~a minimum of~~ three hours of specific (physical, occupational or speech) or combined rehabilitation therapy services per patient day;

(4) physical therapy assistants and occupational therapy assistants shall be supervised on-site by physical therapists or occupational therapists;

(5) rehabilitation aides shall have documented training appropriate to the activities to be performed and the occupational licensure laws of his or her supervisor. The overall responsibility for the on-going supervision and evaluation of the rehabilitation aide remains with the registered nurse as identified in Subparagraph (a)(1) of this Rule. Supervision by the physical therapist or by the occupational therapist is limited to that time when the therapist is on-site and directing the rehabilitation activities of the aide; and

(6) hours of service by the rehabilitation aide are counted toward the required nursing hours when the aide is working under the supervision of the nurse. Hours of service by the rehabilitation aide are counted toward therapy hours during that time the aide works under the immediate, on-site supervision of the physical therapist or occupational therapist. Hours of service shall not be dually counted for both services. Hours of service by rehabilitation aides in performing nurse-aide duties in areas of the facility other than the rehabilitation unit shall not be counted toward the 5.5 hour minimum nursing requirement described for the rehabilitation unit.

(b) Additional personnel shall be provided as required to meet the needs of the patient, as defined in the comprehensive inpatient rehabilitation evaluation.

History Note: *Authority G.S. 131E-75(b);131E-79;*
RRC Objection due to lack of statutory authority Eff. January 18, 1996;
Eff. May 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

1 10A NCAC 13B .5411 is proposed for readoption as a repeal as follows:

2

3 **10A NCAC 13B .5411 PHYSICAL FACILITY REQUIREMENTS/INPATIENT REHABILITATION**
4 **FACILITIES OR UNIT**

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6 *History Note: Authority G.S. 131E-79;*
7 *Eff. March 1, ~~1996.~~ 1996;*
8 *Repealed Eff. July 1, 2022.*

Fiscal Impact Analysis of Permanent Rule Readoption without Substantial Economic Impact

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Agency:	North Carolina Medical Care Commission Division of Health Service Regulation Acute Care Licensure and Certification Section

Rule Citation(s):

10A NCAC 13B .3801 Nurse Executive
10A NCAC 13B .3903 Preservation of Medical Records
10A NCAC 13B .4103 Provision of Emergency Services
10A NCAC 13B .4104 Medical Director
10A NCAC 13B .4106 Policies and Procedures
10A NCAC 13B .4305 Organization of Neonatal Services
10A NCAC 13B .4603 Surgical and Anesthesia Staff
10A NCAC 13B .4801 Organization
10A NCAC 13B .4805 Safety
10A NCAC 13B .5102 Policy and Procedures
10A NCAC 13B .5105 Sterile Supply Services
10A NCAC 13B .5406 Discharge Criteria for Inpatient Rehabilitation Facilities or Units
10A NCAC 13B .5408 Comprehensive Inpatient Rehabilitation Program Staffing Requirements
10A NCAC 13B .5411 Physical Facility Requirements/Inpatient Rehabilitation Facilities or Unit
(see rule text in Appendix A)

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Rulemaking Authority:	G.S. 131E-75(b); 131E-79;

Impact Summary:	State Government:	No Impact
	Local Government:	No Impact
	Private Entities:	Impact
	Substantial Impact:	No Impact

Introduction and Purpose

Under authority of G.S. 150B-21-3A, Periodic Review and Expiration of Existing Rules, the Medical Care Commission, Rules Review Commission, and the Joint Legislative Administrative Procedure Oversight Committee approved the Subchapter report with classifications for the rules located at 10A NCAC 13B -– Rules for the Licensing of Hospitals on February 10, 2017, May 18, 2017, and July 22, 2017 respectively. As a result of the periodic review of rules, 40 rules were determined as "Necessary With Substantive Public Interest," requiring readoption as new rules for this Subchapter. As of July 1, 2021, three phases totaling 26 rules have been readopted by the N.C. Medical Care Commission (MCC), thereby leaving 14 rules for readoption.

There are 120 licensed Hospitals in North Carolina. This fiscal analysis addresses the fourth phase with the remaining 14 rules for readoption following the periodic review of rules. Fives rules were revised with substantive changes to update practices and language, address previous Rule Review Committee objections, provide clarity, remove ambiguity, and implement technical changes. The changes will also allow reference to the General Statute. (Rules (10A NCAC 13B, .3801, .3903, .4103, .4104, and .5408).

Eight rules were revised without substantive changes (Rules 10A NCAC 13B .4106, .4305, .4603, .4801, .4805, .5102, .5105, .5406) and one rule is being repealed (Rule 10A NCAC 13B .5411). Per statute, these rules are not subject to a fiscal analysis therefore a discussion of these rules is not included in the document.

Description of Proposed Rules and Anticipated Fiscal Impact

Rule 10A NCAC 13B .3801- Nurse Executive

The agency is proposing to readopt this rule with substantive changes. This rule establishes the criteria for the assignment of nursing staff for the provision of care according to a written plan. Changes clarify that the written plan is the plan of care that reflects the patient's goals and the nursing care to be provided to meet the patient's needs. The Nurse Executive must ensure that there are adequate numbers of clinical nursing personnel with the appropriate education, experience, licensure, competence, and specialized qualifications to provide nursing care for each patient in accordance with the individual needs of each patient specified in the plan of care. Adding this language will have no additional impact on the role of the Nurse Executive as this is a federal requirement under CMS regulations to receive federal funding and represents current practice. There is no fiscal impact associated with the amendment of this rule.

In addition, the agency referenced the General Statute for the practice of nursing services. Referencing the statute does not change or expand the scope of the nursing care services, it just clarifies the specific statutes that are applicable to the practice of nursing.

Rule 10A NCAC 13B .3903 - Preservation of Medical Records

The agency is proposing to amend this rule. This rule establishes the criteria for the preservation of medical records. Currently, the rule requires public notice to be given when a hospital is going to destroy medical records after the 11 year storage period in at least a written notice to the former patient or their representative and the display of an advertisement in a newspaper of general circulation in the area of the facility. The agency is updating the rule to not require patient notification before the destruction of the medical records. A review of other states' regulations in this space span from no regulations at all to a thirty year record retention policy.[1] In general, two other states have similar rules that require notification before destruction of medical records by hospitals (North Dakota and Pennsylvania) but most states do not require this notification. In addition to being in the minority of states with notification rules, requiring printed notice in the newspaper no longer makes sense as printed newspapers have dropped significantly in circulation and availability. Not requiring printed notice to either patients or their representatives and not requiring an advertisement to be printed in the newspaper will most likely save the hospital money.

[1] Protecting Patient Information after a Facility Closure. Appendix C: States with Laws, Regulations, or Guidelines Pertaining to Facility Closure. Accessed 9/27/2021. https://library.ahima.org/doc?oid=105007#.YUzI2zUpBhF

The amount of money saved would be dependent upon the cost of the newspaper advertisement which differs between localities and also the number of patients they were required to notify in written form.

The loss of the notification requirement may increase the likelihood that a patient is unable to access their old medical records if they are not informed about the facility disposing of their records. However, it is unknown how many patients this rule change will impact as well as what the actual consequences of not being able to access medical records that are over a decade old would be. Overall, this rule change likely represents a cost savings to facilities.

Rule 10A NCAC 13B .4103 - Provision of Emergency Services

The agency is proposing to readopt this rule with substantive changes. This rule establishes the criteria for the provision of emergency services and requirements for interoperable communication. This rule is being changed to update the interoperable communication system to the North Carolina Voice Interoperability Plan for Emergency Responder (NC VIPER). All hospitals, with emergency departments, that receive patients from EMS, have access to the VIPER system. Each facility has been assigned an exclusive talk group (channel) to communicate with EMS units. All radios operating on the VIPER system are required to have the minimum statewide template installed. The template provides the facility with interoperability channels to communicate with public safety agencies and also the NC Emergency Management 24-hour Watch Center in the event of a disaster, terrorist event or total loss of traditional communications means (internet, telephone, cell phone).

The VIPER system is almost completely built out, and offers +95% statewide coverage, from the mobile level. The original VIPER radios were provided to all of the hospitals through a federal grant, passed through the Healthcare Preparedness Program (HPP) approximately 12-15 years ago. The radios became the property of the facility and it has been their responsibility for the maintenance and upgrades. The VIPER system is scheduled for a system upgrade to P25 phase II (TDMA) in 2025. The original radios are not capable of this upgrade and the facilities will need to replace them by that target date. OEMS has been pushing out information to the facilities since July 2019, on this required system upgrade. Many facilities have already completed the replacement of their VIPER units. The rule already requires operators to install, operate, and maintain their radios – this rule change simply updates the rule to reflect the current technology that is already being used by operators. There is no fiscal impact associated with the readoption of this rule.

Changes were also made to update language to current terminology, update reference to reflect rule recodification change, and included other technical changes.

Rule 10A NCAC 13B .4104 - Medical Director

The agency is proposing to readopt this rule with substantive changes. This rule establishes both the qualifications of the physician directing Level I, II, and III emergency services and the criteria for the duties and authority of the Medical Director/Director of Emergency Services. This rule is being updated to reflect a historical Rules Review Commission objection that determined the agency has no authority for regulating the qualifications of the director of emergency services.

The hospital’s medical staff establishes the criteria for the qualifications for the director of the hospital’s emergency services in accordance with State law and acceptable standards of practice. The qualifications include necessary education, experience, and specialized training. This is a federal requirement under CMS regulations to receive federal funding.

The proposed change removes the requirement for the director of emergency medical services to serve as chairman of the medical staff committee. The medical staff also establishes the criteria and delineates the qualifications a medical staff member must possess, in order to be granted privileges for the supervision of the provision of emergency care services and to serve as chairman of the medical staff committee. This is a federal requirement. There is no fiscal impact associated with the readoption of this rule.

Rule 10A NCAC 13B .5408 - Comprehensive Inpatient Rehabilitation Program Staffing Requirements

This rule establishes the inpatient rehabilitation program staffing requirements. The agency is proposing to readopt this rule with substantive changes. An historical Rules Review Commission Objection determined that the rule is confusing, and the agency lacked statutory authority to set staff qualification requirements. Revisions to the rule have satisfied this objection and technical changes were made. These rule changes should not result in any changes in practice and simply provide clarity to the rule’s language.

There is no fiscal impact associated with the amendment of this rule.

Impact Summary

These readoptions update rules to account for current practices and language, remove ambiguity, address historical Rule Review Commission objections, and implement technical changes. Changes also allow reference to the General Statute where appropriate. The rule change that is likely to have the largest impact is Rule 10A NCAC 1B .3903 – Preservation of Medical Records. It will likely result in an unknown cost savings to the facility. The other rules are unlikely to have any fiscal impact.

Appendix A

10A NCAC 13B .3801 is proposed for readoption with substantive changes as follows:

SECTION .3800 - NURSING SERVICES

10A NCAC 13B .3801 NURSE EXECUTIVE

(a) Whether the facility utilizes a centralized or decentralized organizational structure, a nurse executive shall be responsible for the coordination of nursing organizational functions.

(b) A nurse executive shall develop facility wide patient care programs, ~~policies~~ policies, and procedures that describe how the nursing care needs of patients are assessed, ~~met~~ met, and evaluated.

(c) The nurse executive shall develop and adopt, subject to the approval of the facility, a set of administrative policies and procedures to establish a framework to accomplish required functions.

(d) There shall be scheduled ~~meetings,~~ meetings ~~at least~~ every 60 ~~days,~~ days of the members of the nursing staff to evaluate the quality and efficiency of nursing services. Minutes of these meetings shall be maintained.

(e) The nurse executive shall be responsible for:

(1) the development of a written organizational plan which describes the levels of accountability and responsibility within the nursing organization;

(2) identification of standards and policies and procedures related to the delivery of nursing care;

(3) planning for and the evaluation of the delivery of nursing care delivery system;

(4) establishment of a mechanism to validate qualifications, knowledge, and skills of nursing personnel;

(5) provision of orientation and educational opportunities related to expected nursing ~~performance,~~ performance and maintenance of records pertaining thereto;

(6) implementation of a system for performance evaluation;

(7) provision of nursing care services in conformance with ~~the North Carolina Nursing Practice Act;~~ G.S. 90-171.20(7) and G.S. 90-171.20(8);

(8) assignment of nursing staff to clinical or managerial responsibilities based upon educational preparation, in conformance with licensing laws and an assessment of current competence; and

(9) staffing nursing units with ~~sufficient~~ personnel in accordance with a written ~~plan.~~ plan of care to meet the needs of the patients.

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .3903 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .3903 PRESERVATION OF MEDICAL RECORDS

(a) The manager of medical records service shall maintain medical records, whether original, computer media, or microfilm, for ~~a minimum of~~ 11 years following the discharge of an adult patient.

(b) The manager of medical records shall maintain medical records of a patient who is a minor until the patient's 30th birthday.

(c) If a hospital discontinues operation, its management shall make known to the Division where its records are stored. Records shall be stored in a business offering retrieval services for ~~at least~~ 11 years after the closure date.

~~(d) The hospital shall give public notice prior to destruction of its records, to permit former patients or representatives of former patients to claim the record of the former patient. Public notice shall be in at least two forms: written notice to the former patient or their representative and display of an advertisement in a newspaper of general circulation in the area of the facility.~~

~~(e)~~ (d) The manager of medical records may authorize the microfilming of medical records. Microfilming may be done on or off the premises. If done off the premises, the facility shall provide for the confidentiality and safekeeping of the records. The original of microfilmed medical records shall not be destroyed until the medical records department has had an opportunity to review the processed film for content.

~~(f)~~ (e) Nothing in this Section shall be construed to prohibit the use of automation in the medical records service, provided that all of the provisions in this Rule are met and the information is readily available for use in patient care.

~~(g)~~ (f) Only personnel authorized by ~~state~~ State laws and Health Insurance Portability and Accountability Act (HIPAA) regulations shall have access to medical records. Where the written authorization of a patient is required for the release or disclosure of health information, the written authorization of the patient or authorized representative shall be maintained in the original record as authority for the release or disclosure.

~~(h)~~ (g) Medical records are the property of the hospital, and they shall not be removed from the facility jurisdiction except through a court order. Copies shall be made available for authorized purposes such as insurance claims and physician review.

History Note: *Authority G.S. ~~90-21.20B;~~ 131E-75(b); 131E-79; 131E-97;*
Eff. January 1, 1996;
Amended Eff. July 1, ~~2009.~~ 2009;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4103 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .4103 PROVISION OF EMERGENCY SERVICES

(a) Any ~~of any~~ facility providing emergency services shall establish and maintain policies requiring ~~appropriate~~ medical screening, treatment and transfer services for any individual who presents to the facility emergency department and on whose behalf treatment is requested regardless of that person's ability to pay for medical services and without delay to inquire about the individual's method of payment.

(b) Any facility providing emergency services under the rules of this Section shall install, ~~operate~~ operate, and maintain, on a 24-hour per day basis, an emergency two-way radio ~~licensed by the Federal Communications Commission in the Public Safety Radio Service~~ capable of ~~establishing~~ accessing the North Carolina Voice Interoperability Plan for Emergency Responders (VIPER) radio network for voice ~~radio~~ communication with ~~ambulance units~~ EMS providers transporting patients to ~~said~~ the facility or ~~having any written procedure or agreement for handling emergency services with the local ambulance service, rescue squad or other trained medical~~ or provide on-line medical direction for EMS personnel.

(c) All communication equipment shall be in compliance with ~~current~~ the rules ~~established by North Carolina Rules for Basic Life Support/Ambulance Service (10 NCAC 3D .1100) adopted by reference with all subsequent amendments. Referenced rules are available at no charge from the Office of Emergency Medical Services, 2707 Mail Service Center, Raleigh, N.C. 27699-2707.~~ set forth in 10A NCAC 13P, Emergency Medical Services and Trauma Rules.

History Note: Authority G.S. 131E-75(b); 131E-79;
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4104 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .4104 MEDICAL DIRECTOR

(a) The governing body shall establish the qualifications, duties, and authority of the director of emergency services. Appointments shall be recommended by the medical staff and approved by the governing body.

(b) The medical staff credentials committee shall approve the mechanism for emergency privileges for physicians employed for brief periods of time such as evenings, ~~weekends~~ weekends, or holidays.

(c) Level I and II emergency services shall be directed and supervised by a ~~physician with experience in emergency care.~~ physician.

(d) Level III services shall be directed and supervised by a ~~physician with experience in emergency care or through a multi-disciplinary medical staff committee. The chairman of this committee shall serve as director of emergency medical services.~~ physician.

History Note: Authority G.S. 131E-75(b); 131E-79; 131E-85(a);
RRC objection due to lack of statutory authority Eff. July 13, 1995;

Eff. January 1, ~~1996.~~ 1996;

Readopted Eff. July 1, 2022.

10A NCAC 13B .4106 is proposed for readoption without substantive changes as follows:

10A NCAC 13B .4106 POLICIES AND PROCEDURES

Each emergency department shall establish written policies and procedures ~~which~~ that specify the scope and conduct of patient care to be provided in the emergency areas. They shall include the following:

(1) the location, storage, and procurement of medications, blood, supplies, equipment and the procedures to be followed in the event of equipment failure;

(2) the initial management of patients with burns, hand injuries, head injuries, fractures, multiple injuries, poisoning, animal bites, gunshot or stab ~~wounds~~ wounds, and other acute problems;

(3) the provision of care to an unemancipated minor not accompanied by a parent or guardian, or to an unaccompanied unconscious patient;

(4) management of alleged or suspected child, ~~elder~~ elder, or adult abuse;

(5) the management of pediatric emergencies;

(6) the initial management of patients with actual or suspected exposure to radiation;

(7) management of alleged or suspected rape victims;

(8) the reporting of individuals dead on arrival to the proper authorities;

(9) the use of standing orders;

(10) tetanus and rabies prevention or prophylaxis; and

(11) the dispensing of medications in accordance with ~~state~~ State and federal laws.

History Note: Authority G.S. 131E-75(b); 131E-79;

Eff. January 1, ~~1996.~~ 1996;

Readopted Eff. July 1, 2022.

10A NCAC 13B .4305 is proposed for readoption without substantive changes as follows:

10A NCAC 13B .4305 ORGANIZATION OF NEONATAL SERVICES

(a) The governing body shall approve the scope of all neonatal services and the facility shall classify its capability in providing a range of neonatal services using the following criteria:

(1) LEVEL I: Full-term and pre-term neonates that are stable without complications. This may ~~include,~~ include infants who are small for gestational age or large for gestational age neonates.

(2) LEVEL II: Neonates or infants that are stable without complications but require special care and frequent feedings; infants of any weight who no longer require Level III or LEVEL IV neonatal

services, but who still require more nursing hours than normal infant. This may include infants who require close observation in a licensed acute care ~~bed~~ bed.

(3) LEVEL III: Neonates or infants that are high-risk, small (or approximately 32 and less than 36 completed weeks of gestational age) but otherwise healthy, or sick with a moderate degree of illness that are admitted from within the hospital or transferred from another facility requiring intermediate care services for sick infants, but not requiring intensive care. The beds in this level may serve as a "step-down" unit from Level IV. Level III neonates or infants require less constant nursing care, but care does not exclude respiratory support.

(4) LEVEL IV (Neonatal Intensive Care Services): High-risk, medically unstable or critically ill neonates approximately under 32 weeks of gestational age, or infants, requiring constant nursing care or supervision ~~not limited to~~ that includes continuous cardiopulmonary or respiratory support, complicated surgical procedures, or other intensive supportive interventions.

(b) The facility shall provide for the availability of equipment, supplies, and clinical support services.

(c) The medical and nursing staff shall develop and approve policies and procedures for the provision of all neonatal services.

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. January 1, 1996;
Temporary Amendment Eff. March 15, 2002;
Amended Eff. April 1, ~~2003.~~ 2003;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4603 is proposed for readoption without substantive changes as follows:

10A NCAC 13B .4603 SURGICAL AND ANESTHESIA STAFF

~~(a)~~ The facility shall develop processes ~~which require that~~ that require each individual ~~provides~~ provide only those services for which proof of licensure and competency can be demonstrated. The facility shall require that:

~~(b) The facility shall require that:~~

(1) when anesthesia is administered, a ~~qualified~~ physician is ~~immediately~~ available in the facility to provide care in the event of a medical emergency;

(2) a roster of practitioners with a delineation of current surgical and anesthesia privileges is available and maintained for the service;

(3) an on-call schedule of surgeons with privileges to be available at all times for emergency surgery and for post-operative clinical management is maintained;

(4) the operating room is supervised by a ~~qualified~~ registered nurse or doctor of medicine or osteopathy; and

(5) an operating room register which shall include date of the operation, name and patient identification number, names of surgeons and surgical assistants, name of anesthetists, type of anesthesia given, pre- and post-operative diagnosis, type and duration of surgical procedure, and the presence or absence of complications in surgery is maintained.

History Note: Authority G.S. 131E-75(b); 131E-79; 131E-85;
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4801 is proposed for readoption without substantive changes as follows:

SECTION .4800 - DIAGNOSTIC IMAGING

10A NCAC 13B .4801 ORGANIZATION

(a) Imaging services shall be under the supervision of a full-time radiologist, consulting radiologist, or a ~~physician~~ physician. ~~experienced in the particular imaging modality and the~~ The physician in charge ~~must~~ shall have the credentials required by facility policies.

(b) ~~Activities of the imaging service may include radio-therapy.~~ Radio-therapy is a type of imaging service.

(c) All imaging equipment shall be operated under professional supervision by ~~qualified~~ personnel trained in the use of imaging equipment and knowledgeable of all applicable safety precautions required by the North Carolina Department of ~~Environment and Natural Resources,~~ Health and Human Services, Division of ~~Environmental~~ Health Service Regulation, Radiation Protection ~~Section.~~ Section set forth in 10A NCAC 15, hereby incorporated by reference including subsequent amendments. ~~Copies of regulations are available from the N.C. Department of Environment and Natural Resources, Radiation Protection Section, 3825 Barrett Drive, Raleigh, NC 27609 at a cost of sixteen dollars ($16.00) each~~.

History Note: Authority G.S. 131E-75(b); 131E-79;
RRC objection due to lack of statutory authority and ambiguity Eff. July 13, 1995;
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .4805 is proposed for readoption without substantive changes as follows:

10A NCAC 13B .4805 SAFETY

(a) The facility shall require that all imaging equipment is operated under the supervision of a physician and by qualified personnel.

(b) The facility shall require that proper caution is exercised to protect all persons from exposure to radiation.

(c) Safety inspections of the imaging department, including equipment, shall be conducted by the North Carolina Division of ~~Environmental Health,~~ Health Service Regulation, Radiation Protection ~~Services~~ Section. Copies of the report shall be available for review by the Division.

(d) The governing authority shall appoint a radiation safety committee. The committee shall ~~include but is not limited to:~~ include:

(1) a physician experienced in the handling of radio-active isotopes and their therapeutic use; and

(2) other representatives of the medical staff.

(e) All radio-active isotopes, whether for diagnostic, therapeutic, or research purposes shall be received, handled, and disposed of in accordance with the requirements of the North Carolina Department of ~~Environment and Natural Resources,~~ Health and Human Services, Division of ~~Environmental Health,~~ Health Service Regulation, Radiation Protection ~~Services Section.~~ Section set forth in 10A NCAC 15, hereby incorporated by reference including subsequent amendments. ~~Copies of regulations are available from the North Carolina Department of Environment, Health, and Natural Resources, Division of Radiation Protection, 3825 Barrett Drive, Raleigh, NC 27609 at a cost of six dollars ($6.00) each.~~

History Note: *Authority G.S. 131E-75(b); 131E-79;*
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .5102 is proposed for readoption without substantive changes as follows:

10A NCAC 13B .5102 POLICY AND PROCEDURES

(a) Each facility department or service shall establish and maintain written infection control policies and procedures. These shall ~~include but are not limited to:~~ include:

(1) the role and scope of the service or department in the infection control program;

(2) the role and scope of surveillance activities in the infection control program;

(3) the methodology used to collect and analyze data, maintain a surveillance program on nosocomial infection, and the control and prevention of infection;

(4) the specific precautions to be used to prevent the transmission of infection and isolation methods to be utilized;

(5) the method of sterilization and storage of equipment and supplies, including the reprocessing of disposable items;

(6) the cleaning of patient care areas and equipment;

(7) the cleaning of non-patient care areas; and

(8) exposure control plans.

(b) The infection control committee shall approve all infection control policies and procedures. The committee shall review all policies and procedures ~~at least~~ every three years and indicate the last date of review.

(c) The infection control committee shall meet ~~at least~~ quarterly and maintain minutes of meetings.

History Note: Authority G.S. 131E-75(b); 131E-79;
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff July 1, 2022.

10A NCAC 13B .5105 is proposed for readoption without substantive changes as follows:

10A NCAC 13B .5105 STERILE SUPPLY SERVICES

The facility shall provide for the following:

(1) decontamination and sterilization of equipment and supplies;

(2) monitoring of sterilizing equipment on a routine schedule;

(3) establishment of policies and procedures for the use of disposable items; and

(4) establishment of policies and procedures addressing shelf life of stored sterile items.

History Note: Authority G.S. 131E-75(b); 131E-79;
Eff. January 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .5406 is proposed for readoption without substantive changes as follows:

10A NCAC 13B .5406 DISCHARGE CRITERIA FOR INPATIENT REHABILITATION FACILITIES OR UNITS

(a) Discharge planning shall be an integral part of the patient's treatment plan and shall begin upon admission to the facility. After established goals have been reached, or a determination has been made that care in a less intensive setting would be appropriate, or that further progress is unlikely, the patient shall be discharged to an appropriate setting. Other reasons for discharge may include an inability or unwillingness of patient or family to cooperate with the planned therapeutic program or medical complications that preclude a further intensive rehabilitative effort. The facility shall involve the patient, family, staff ~~members~~ members, and referral sources in discharge planning.

(b) The case manager shall facilitate the discharge or transfer process in coordination with the facility social worker.

(c) If a patient is being referred to another facility for further care, ~~appropriate~~ documentation of the patient's current status shall be forwarded with the patient. A ~~formal~~ discharge summary shall be forwarded within 48 hours following discharge and shall include the reasons for referral, the diagnosis, functional limitations, services provided, the results of services, referral action ~~recommendations~~ recommendations, and activities and procedures used by the patient to maintain and improve functioning.

History Note: Authority G.S. 131E-75(b); 131E-79;
Eff. March 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .5408 is proposed for readoption with substantive changes as follows:

10A NCAC 13B .5408 COMPREHENSIVE INPATIENT REHABILITATION PROGRAM STAFFING REQUIREMENTS

(a) The staff of the inpatient rehabilitation facility or unit shall ~~include at a minimum:~~ include:

(1) the inpatient rehabilitation facility or unit shall be supervised by a rehabilitation ~~nurse.~~ nurse as defined in Rule .5401 of this Section. The facility shall ~~identify the nursing skills necessary to meet the needs of the rehabilitation patients in the unit and~~ assign staff qualified to meet those needs;

(2) the minimum nursing hours per patient in the rehabilitation unit shall be 5.5 nursing hours per patient day. At no time shall direct care nursing staff be less than two full-time equivalents, one of which must be a registered nurse;

(3) the inpatient rehabilitation unit shall employ or provide by contractual agreements ~~sufficient~~ therapist to provide ~~a minimum of~~ three hours of specific (physical, occupational or speech) or combined rehabilitation therapy services per patient day;

(4) physical therapy assistants and occupational therapy assistants shall be supervised on-site by physical therapists or occupational therapists;

(5) rehabilitation aides shall have documented training appropriate to the activities to be performed and the occupational licensure laws of his or her supervisor. The overall responsibility for the on-going supervision and evaluation of the rehabilitation aide remains with the registered nurse as identified in Subparagraph (a)(1) of this Rule. Supervision by the physical therapist or by the occupational therapist is limited to that time when the therapist is on-site and directing the rehabilitation activities of the aide; and

(6) hours of service by the rehabilitation aide are counted toward the required nursing hours when the aide is working under the supervision of the nurse. Hours of service by the rehabilitation aide are counted toward therapy hours during that time the aide works under the immediate, on-site supervision of the physical therapist or occupational therapist. Hours of service shall not be dually

counted for both services. Hours of service by rehabilitation aides in performing nurse-aide duties in areas of the facility other than the rehabilitation unit shall not be counted toward the 5.5 hour minimum nursing requirement described for the rehabilitation unit.

(b) Additional personnel shall be provided as required to meet the needs of the patient, as defined in the comprehensive inpatient rehabilitation evaluation.

History Note: *Authority G.S. 131E-75(b);131E-79;*
RRC Objection due to lack of statutory authority Eff. January 18, 1996;
Eff. May 1, ~~1996.~~ 1996;
Readopted Eff. July 1, 2022.

10A NCAC 13B .5411 is proposed for readoption as a repeal as follows:

10A NCAC 13B .5411 PHYSICAL FACILITY REQUIREMENTS/INPATIENT REHABILITATION FACILITIES OR UNIT

History Note: *Authority G.S. 131E-79;*
Eff. March 1, ~~1996.~~ 1996;
Repealed Eff. January 1, 2022.