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
MICROSOFT TEAM VIDEO LINK: Click here to join the meeting
OR
DIAL-IN: 1-984-204-1487 PASSCODE: 671 316 429#

Friday, February 12, 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. Approval of Minutes (Action Item)…..……..……..……..Dr. John Meier

- **November 12-13, 2020 (Medical Care Commission Quarterly Meeting) (See Exhibit A)**
- **December 9, 2020 (Full Commission Emergency Conference Call)** – To approve temporary rulemaking for Adult Care Home & Family Care Home Rules. **(See Exhibit A-1)**
- **January 21, 2021 (Executive Committee Conference Call)** – To approve the final sale of bonds for CaroMont Health. **(See Exhibit B-1)**

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

Quarterly Report on Bond Program **(See Exhibit B)**

VII. Bond Projects (Action Items)

A. Vidant Health (Greenville)……Geary W. Knapp

Compliance Summary:

- **No Violations of MCC Compliance policy**

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

Yes; Vidant has a formal Tax Exempt Bond Policy that deals with post tax issuance compliance.

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

The Chief Financial Officer of Vidant Health is responsible for compliance.

3) What is the Organization's compliance monitoring plan?

The organization uses the compliance checklist provided by Bond Counsel with each issue as the guide of what is required and the checklist is completed annually as well as the annual compliance checklist from the NC Medical Care Commission. Vidant reports and shows the compliance checklist to the Finance Committee of the Board on an annual basis.

4) How will the Organization report compliance deficiencies to leadership and the Board?

The finance committee would hear from management of any deficiency at their meeting. The CEO of the system is on the Vidant Medical Center Board and would hear the same report the committee hears. In reality, the issue would be verbally communicated as soon as a deficiency is known by the CFO. The Finance Committee has in their charter oversight and approval over all bond issues.

Selected Application Information:

1) Information from FY20 Audit of Vidant Health:

Net Income	$ 63,360
Operating Revenue	$ 1,974,635
Operating Expenses	($ 2,008,582)
Net Cash provided by Operating Activities	$ 47,850,000
Change in Net Assets	$ 98,202,000
Unrestricted Cash	$111,868,000
Change in Cash	$ 12,782,000

2) Ratings:

Moody's – A2 / Outlook Stable

3) Community Benefits:

Community Benefits (FY19)	$266,554,562
Estimated Costs of Treating Bad Debt Patients	$56,829,803

4) Long Term Debt Service Coverage Ratios:

Actual FYE 2020	3.82
Forecasted FYE 2021	5.64
Forecasted FYE 2022	5.04
Forecasted FYE 2023	5.08
Forecasted FYE 2024	5.22
Forecasted FYE 2025	5.36

5) Transaction Participants:

Financial Advisor:	Ponder & Co.
Bond Counsel:	Womble Bond Dickinson (US) LLP
Bank Purchaser:	Truist Bank, N.A.
Bank Counsel:	Moore & Van Allen PLLC
Trustee:	U.S. Bank, N.A.
Trustee Counsel:	*To Be Determined*
Borrower Counsel:	KL Gates LLP

6) Board Diversity:

VIDANT HEALTH

Male:	10
Female:	1
Total:	11

Caucasian:	9
African American:	2
	11

VIDANT MEDICAL CENTER

Male:	15
Female:	5
Total:	20

Caucasian:	16
African American:	4
	20

(See Exhibit G for Bond Sale Approval Form)

Resolution: The Commission grants preliminary approval to a transaction for Vidant Health to (1) provide funds, to be used, together with other available funds, to advance refund, on a *taxable* basis, the callable portion of the North Carolina Medical Care Commission $297,100,000 Health Care Facilities Revenue Bonds, Series 2015, outstanding callable portion as of the date of the refunding in the amount of $101,920,000 and (2) 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 (7/1/2025) of the Series 2015 Bonds. The intent of the proposed Bond Issue is to take advantage of the low interest rate environment and to enter into a forward agreement with established terms for the exchange of the taxable bonds for tax-exempt bonds. The proposed transaction in its entirety will result in an estimated NPV savings of $10,700,000. The proposed transaction is in accordance with an application received as follows:

ESTIMATED SOURCES OF FUNDS

Principal amount of bonds to be issued	$123,780,000
Total Sources of Funds	**$123,780,000**

ESTIMATED USES OF FUNDS

Escrow Amount to refund Series 2015	$123,373,750
Financial Advisor Fee	165,000
Verification Agent Fee	3,000
Escrow Agent Fee	3,000
Local Government Commission Fee	8,750
Trustee Fee	8,000
Trustee Counsel	6,000
Corporation Counsel	62,500
Bank Purchaser Counsel	60,000
Bond Counsel	90,000
Total Uses	**$123,780,000**

Tentative approval is given with the understanding that the governing board of Vidant Health 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. § 13lA (Health Care Facilities Finance Act).

4. The Executive Committee of the Commission is delegated the authority to approve the issuance or conversion of bonds for this project and may approve the issuance or conversion of such greater amount 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 or converted 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 patients.

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 provide the Commission annually a copy of Schedule H of the IRS form 990 to demonstrate community benefits provided by the borrower.

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.

9. All health care facilities and services directly or indirectly owned or controlled by the health care organization, including physician practices, shall be available to Medicare and Medicaid patients with no limitations imposed as a result of the source of reimbursement.

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

B. Forest at Duke (Durham)……..Geary W. Knapp

Compliance Summary:

- **No Violation of MCC 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?

Chief Financial Officer (Karen Henry)

3) What is the Organization's compliance monitoring plan?

The CFO utilizes a compliance checklist and maintains a binder for each bond issuance with all documentation. The compliance monitoring plan encompasses monthly, quarterly, and annual procedures.

4) How will the Organization report compliance deficiencies to leadership and the Board?

For immediacy purposes, an e-mail to the Leadership Team and Board Members would be sent. Compliance issues would be discussed at quarterly Board meetings and applicable Board Committee meetings, as well as weekly Leadership Team meetings.

Selected Application Information:

1) Information from FYE 2020 (9/30 Year End) Audit of The Forest at Duke, Inc.:

Net Income	$ 3,429,212
Operating Revenue	$ 26,783,574
Operating Expenses	($ 24,681,168)
Net Cash provided by Operating Activities	$ 7,390,014
Change in Net Assets	$ 3,488,023
Unrestricted Cash	$ 5,190,711
Change in Cash	($ 1,919,454)

***Cash Outflows included purchase of investments, property, & equipment, payment of bond principal, and entrance fee refunds

2) Ratings:

Fitch – 'A'

3) Community Benefits (FYE 2019):

Per N.C.G.S § 105 – 5.03% (Eligible for 100% property tax exclusion)

- Total Community Benefits and Charity Care - $1,331,480

4) Long-Term Debt Service Coverage Ratios:

Actual FYE 2020	3.51
Forecasted FYE 2021	5.20
Forecasted FYE 2022	1.53
Forecasted FYE 2023	1.56
Forecasted FYE 2024	1.62
Forecasted FYE 2025	1.65

5) Transaction Participants:

Bond Counsel:	Robinson, Bradshaw, & Hinson, P.A.
Underwriter:	B.C. Ziegler and Company
Underwriter Counsel:	Parker Poe Adams & Bernstein LLP
Borrower Counsel:	Womble Bond Dickinson (US) LLP
Accountant (AUP Forecast):	Clifton Larson Allen
Bank Purchaser:	TBD
Bank Counsel:	TBD
Trustee:	U.S. Bank, N.A.
Trustee Counsel:	TBD

6) Board Diversity:

Male:	9
Female:	6
Total:	15

Caucasian:	12
African American:	3
	15

7) Diversity of Residents (370 Residents):

Male:	30%
Female:	70%
Total:	100%

Caucasian:	95%
African American/Asian/Indian/Other:	5%
Total:	100%

(See Exhibit H for Fee Schedule and Bond Sale Approval Form)

Resolution: The Commission grants preliminary approval for The Forest at Duke, Inc. project to provide funds to be used, together with other available funds, to ***construct*** a new healthcare facility building that includes the following:

5-Story 90 Licensed Bed Health Care Facility (110,000 square feet)

- "Small House" Model
- House = 10 Private Rooms w/bathroom designed around common spaces and support areas
- House total will be 9 Houses (90 Licensed Beds)

Capital expenditures for the new construction shall be included as listed below, all in accordance with a preliminary application, plans and specifications and participation as follows:

ESTIMATED SOURCES OF FUNDS

Principal amount of bonds to be issued	$ 57,575,000
Total Sources	**$ 57,575,000**

ESTIMATED USES OF FUNDS

Construction Contracts	39,582,115
Construction Contingency (1% of Construction Contracts)	395,821
Architect Fees	2,383,602
Architect's Reimbursables	50,000
Moveable Equipment	1,710,000
Survey, Tests, Insurance	154,038
Consultant Fees (Landscape/Kitchen/3rd Party Commissioning)	399,300
DHSR Reimbursables (G.S. § 131-E-267)	30,000
Bond Interest during Construction	6,523,307
Debt Service Reserve Fund	5,146,300
Underwriter Discount/Placement Fee	574,700
Feasibility Study Fee	115,000
Accountant Fee	20,000
Corporation Counsel	75,000
Bond Counsel	95,000
Rating Agency	75,000
Trustee Fee & Counsel	11,250
Bank Counsel	45,000
Printing Cost	7,500
Local Government Commission	8,750
Underwriter Counsel & Blue Sky Fee	75,000
Bank Fee	25,000
Appraisal/Survey/Title Fee	73,317
Total Uses	**$ 57,575,000**

Tentative approval is given with the understanding that the governing board of The Forest at Duke, Inc. accepts the following conditions:

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

2. Any required certificate of need must be in effect at the time of the issuance of the bonds or notes.

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

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

5. 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%).

6. 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.

7. 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.

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

9. 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 I for presentation)

VIII. Old Business (Discuss Rules, fiscal note, and comments submitted)

A. Rules for Adoption (Action Items)

1. Healthcare Personnel Registry Rule……..…….Nadine Pfeiffer & Jana Busick

Amendment of 1 following emergency and temporary rulemaking for nurse aide reciprocity

- Rule: 10A NCAC 13O .0301
  (See Exhibits C thru C-2)

IX. New Business (Discuss Rules & Fiscal Note)

A. Rules for Initiating Rulemaking Approval (Action Items)

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

Readoption of 13 rules following Periodic Review & 3 rule amendments

- Rules: 10A NCAC 13K.1109, .1112 -.1116, .1201, and .1204 - .1212
  (See Exhibits D thru D-2)

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

Amendment of one rule for technical changes

- Rule: 10A NCAC 13D .2001
  (See Exhibit D-3)

X. Mobile Disaster Hospital Update……Tom Mitchell & Geary W. Knapp

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 May 14, 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 between this date and May 14, 2021.

XII. Meeting Adjournment

EXHIBIT A

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL CARE COMMISSION PLANNING SESSION
DIVISION OF HEALTH SERVICE REGULATION
809 RUGGLES DRIVE RALEIGH, NORTH CAROLINA 27603
CONFERENCE ROOM #026A – EDGERTON BUILDING
or
VIDEO CONFERENCE (LINK: Join Microsoft Teams Meeting))
or
DIAL-IN (1-984-204-1487 / Passcode: 249668659#)

NOVEMBER 12, 2020
3:00 P.M.

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
CONFERENCE ROOM - #026A - EDGERTON BUILDING
or
VIDEO CONFERENCE (LINK: Click here to join the meeting))
or
DIAL-IN (1-984-204-1487 / Passcode: 555004373#)
Friday, November 13, 2020
9:00 a.m.

MINUTES

I. MEETING ATTENDANCE – MCC PLANNING SESSION - NOVEMBER 12, 2020

MEMBERS PRESENT	MEMBERS ABSENT
John J. Meier, IV, M.D., Chairman	John A. Fagg, M.D.
Joseph D. Crocker, Vice-Chairman	Linwood B. Hollowell, III
Kathy G. Barger	Anita L. Jackson, M.D.
Sally B. Cone	Ashley H. Lloyd, D.D.S.
Paul R.G. Cunningham, M.D.	Karen E. Moriarty
Bryant C. Foriest	Neel G. Thomas, M.D.
Eileen C. Kugler, RN, MSN, MPH, FNP	
Albert F. Lockamy, Jr., RPh	
Stephen T. Morton	
Robert E. Schaaf, 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 Nadine Pfeiffer, Rules Review Manager, DHSR Azzie Conley, Chief, Acute & Home Care Licensure Cindy Deporter, Acting Assistant Chief, Acute & Home Care Licensure Megan Lamphere, Chief, Adult Care Licensure Tichina Hamer, Assistant Chief, Adult Care Licensure Beverly Speroff, Assistant Chief, Nursing Home Licensure Tom Mitchell, Chief, Office Emergency Medical Services Crystal Abbott, Auditor, MCC Kathy Larrison, Auditor, MCC Alice Creech, Executive Assistant, MCC	

COMMISSION ACTION:

The Medical Care Commission held its planning meeting on Thursday, November 12, 2020 to review rules and a new MCC Compliance Policy. The agenda was referred without action to the Medical Care Commission meeting on Friday, November 13, 2020.

II. MEETING ATTENDANCE – MCC QUARTERLY MEETING – NOVEMBER 13, 2020

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 Anita L. Jackson, M.D. Eileen C. Kugler, RN, MSN, MPH, FNP Albert F. Lockamy, Jr., RPh Ashley H. Lloyd, D.D.S. Stephen T. Morton Robert E. Schaaf, M.D. Neel G. Thomas, M.D. Jeffrey S. Wilson	Linwood B. Hollowell, III Karen E. Moriarty
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 Nadine Pfeiffer, Rules Review Manager, DHSR Azzie Conley, Chief, Acute & Home Care Licensure	

Cindy Deporter, Acting Assistant Chief, Acute & Home Care Licensure Megan Lamphere, Chief, Adult Care Licensure Libby Kinsey, Assistant Chief, Adult Care Licensure Tichina Hamer, Assistant Chief, Adult Care Licensure Beverly Speroff, Assistant Chief, Nursing Home Licensure Tom Mitchell, Chief, Office Emergency Medical Services Crystal Abbott, Auditor, MCC Kathy Larrison, Auditor, MCC Alice Creech, Executive Assistant, MCC **OTHERS PRESENT** Alice Adams, Robinson Bradshaw & Hinson, PA Jeff Wakefield, UNC Lenoir Healthcare Chris Peek, CaroMont Health David O'Connor, CaroMont Health Shari Reese, CaroMont Health Chuck Mantooth, Appalachian Regional Healthcare Matt Thomas, Appalachian Regional Healthcare Chuck Stafford, Ponder & Co. Bradley Dills, Ponder & Co. Jennifer Wimmer, NC Treasurer's Office Nicolle Karim, NC Treasurer's Office Paru Patel, NC Treasurer's Office	

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

Dr. Meier thanked everyone for taking time out of their busy schedules to take part in the meeting today. He encouraged the members to be on top of their ethics compliance and education. After the roll call was taken, Dr. Meier introduced the NCMCC's newest member Dr. Anita Jackson to the Commission and asked her to introduce herself.

IV. 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.

V. 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.

VI. North Carolina Board of Ethics Letters……..……Dr. John Meier

North Carolina Board of Ethics letters was received for the following newly-appointed member and was noted for a potential conflict of interest:

- Dr. Anita Jackson **(See Exhibit A/1)**

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

- **August 14, 2020 (Medical Care Commission Quarterly Meeting) (See Exhibit A)**

- **August 27, 2020 (Executive Committee)** – To authorize a resolution authorizing the sale and issuance of bonds, the proceeds of which will be loaned to Maryfield, Incorporated. **(See Exhibit B/1)**

- **September 18, 2020 (Executive Committee) –** To authorize the sale of bonds, the proceeds of which are to be loaned to The Presbyterian Homes, Inc. and Glenaire, Inc. **(See Exhibit B/2)**

- **September 25, 2020 (Executive Committee)** To authorize (1) the sale and issuance of bonds, the proceeds of which will be loaned to Friends Homes, Inc. and to (2) gain preliminary approval for the sale of bonds, the proceeds of which are to be loaned to UNC Lenoir Hospital. **(See Exhibit B/3)**

- **October 15, 2020 (Full Commission Emergency Conference Call) –** To approve four rules for Adult Care Homes and Family Care Homes. **(See Exhibit A/2)**

COMMISSION ACTION: *Motion was made by Mr. Joe Crocker to approve the minutes, seconded by Mr. Al Lockamy, and unanimously approved.*

VIII. 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:

November 5, 2020 – Cape Fear Valley Health Series 2012A

- Outstanding Balance: $62,325,000
- Funds provided by: Private Taxable Loan

November 1, 2020 – Novant Health Series 2010A (Redemption)

- Outstanding Balance: $264,165,000
- Funds provided by: Private Taxable Loan

September 29, 2020 – Cone Health Series 2011C and 2011D (Redemption)

- Outstanding Balance: $92,750,000
- Funds provided by: Private Taxable Loan

September 24, 2020 – Hugh Chatham Series 2008 (Conversion)

- New Index (LIBOR) Interest Rate Period
- New Holding Period

IX. Bond Projects (Action Items)

A. UNC Lenoir Health Care (Kinston) – Refunding/Final Approval……..…Geary W. Knapp

Resolution of the North Carolina Medical Care Commission Authorizing the Issuance of $14,690,000 North Carolina Medical Care Commission Health Care Facilities Refunding Revenue Bonds (UNC Lenoir Health Care) Series 2020

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 (including retirement facilities) and to refund bonds previously issued by the Commission; and

WHEREAS, Lenoir Memorial Hospital, Incorporated d/b/a UNC Lenoir Health Care (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 "nonprofit agency" within the meaning of the Act; and

WHEREAS, the Corporation has made application to the Commission for a loan for the purpose of providing funds, together with other available funds, to refund all of the outstanding North Carolina Medical Care Commission Health Care Facilities Revenue Bonds (Lenoir Memorial Hospital Project) Series 2005 (the "Prior Bonds"); and

WHEREAS, the proceeds of the Prior Bonds were used, together with other available funds, to (1) pay or reimburse, as part of the consideration for the conveyance of Lenoir Memorial Hospital (the "Hospital") by the County of Lenoir, North Carolina (the "County") to the Corporation, the redemption price of and accrued interest on the County's outstanding Lenoir Memorial Hospital Revenue Bonds, Series 1995 (the "1995 Bonds") and the County's outstanding Lenoir Memorial Hospital Revenue Bonds, Series 1998 (the "1998 Bonds"), (2) pay a portion of the cost of the 2005 Project described below, and (3) pay all or a portion of the expenses incurred in connection with the issuance of the 2005 Bonds by the Commission. The 2005 Project included (a) an approximately 23,300 square foot expansion of the Wellness Center, (b) the renovation of approximately 7,100 square feet for Pharmacy services, (c) the renovation of approximately 7,100 square feet for Central Services, (d) information systems equipment, (e) magnetic resonance imaging equipment, and (f) other hospital, medical, computer and office equipment; and

WHEREAS, the Commission has determined that the public will best be served by the proposed financing and, by a resolution adopted by the Commission on September 25, 2020, 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 relating to the issuance of the Bonds:

(a) a Trust Agreement dated as of November 1, 2020 (the "Trust Agreement") between the Commission and Truist Bank, as bond trustee (in such capacity, the "Bond Trustee");

(b) a Loan Agreement dated as of November 1, 2020 (the "Loan Agreement") between the Commission and the Corporation;

(c) a Master Trust Indenture dated as of November 1, 2020 (as supplemented, the "Master Indenture") between the Corporation and Truist Bank, as master trustee (the "Master Trustee");

(d) a Supplemental Indenture for Obligation No. 1 dated as of November 1, 2020 ("Supplement No. 1") between the Corporation and the Master Trustee;

(e) Obligation No. 1 dated as of the date of delivery thereof ("Obligation No. 1") from the Corporation to the Commission;

(f) a Contract of Purchase to be dated as of the date of delivery of the Bonds (the "Purchase Agreement") between the Local Government Commission of North Carolina (the "LGC") and BB&T Community Holdings Co., as the initial purchaser of the Bonds (the "Purchaser"), and approved by the Commission and the Corporation;

(g) a Continuing Covenant Agreement dated as of November 1, 2020 (the "Covenant Agreement") between the Corporation and the Purchaser;

(h) a Supplemental Indenture for Obligation No. 2 dated as of November 1, 2020 ("Supplement No. 2," and collectively with Supplement No. 1, the "Supplemental Indentures") between the Corporation and the Master Trustee; and

(i) Obligation No. 2 dated as of the date of delivery thereof ("Obligation No. 2," and collectively with Obligation No. 1, the "Obligations") from the Corporation to the Purchaser; 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, the Supplemental Indentures, the Obligations, and the Covenant Agreement; 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 Series Resolution and not defined herein shall have the same meanings in this Series 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 the issuance of its Health Care Facilities Refunding Revenue Bonds (UNC Lenior Health Care) Series 2020 (the "Bonds"), in the aggregate principal amount of $14,690,000. The Bonds shall mature on April 1, 2036 (the "Maturity Date") and shall bear interest at such rates determined in accordance with the Trust Agreement and shall be subject to the Sinking Fund Requirements set forth in Schedule 1 hereto. During the initial Direct Purchase Period (which is for ten years), the Bonds will bear interest at a fixed rate of interest not to exceed 3.5% per annum, subject to adjustment under certain circumstances.

The Bonds shall be issued as fully registered bonds in (i) denominations of $250,000 and multiples of $5,000 in excess thereof during any Direct Purchase Period, (ii) denominations of $100,000 and multiples of $5,000 in excess of $100,000 during any Short-Term Rate Period or any Medium-Term Rate Period that is not a Direct Purchase Period, and (iii) denominations of $5,000 and integral multiples thereof during any Fixed Rate Period that is not a Direct Purchase Period. Except during a Direct Purchase Period, 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, extraordinary and mandatory redemption, (ii) during any Weekly 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 Bonds shall be applied as provided in Section 2.08 of the Trust Agreement. The Commission hereby finds that the use of the proceeds of the Bonds for a loan to refund the Prior Bonds will accomplish the public purposes set forth in the Act.

Section 5. The forms, terms and provisions of the Trust Agreement and the Loan Agreement are hereby approved in all respects, and the Chairman or Vice Chairman (or any 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 and the Loan Agreement in substantially the forms presented at this

meeting, 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 Agreement are hereby approved in all respects, and the Chairman, Vice Chairman, Secretary or any Assistant Secretary of the Commission (or any member of the Commission designated by the Chairman) is hereby authorized and directed to execute and deliver the Purchase Agreement in substantially the form presented at this meeting, 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 forms of the Bonds set forth in the Trust Agreement are hereby approved in all respects, and the Chairman or Vice Chairman (or any 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 forms 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 forms presented at this meeting, 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, terms and provisions of the Master Indenture, the Supplemental Indentures, the Obligations and the Covenant Agreement are hereby approved in substantially the forms presented to this meeting, together with such changes, modifications and deletions as the Chairman or Vice Chairman (or any member of the Commission designated by the Chairman) and the 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 as provided in Section 5 of this Series Resolution 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 Bonds to the Purchaser in accordance with the Purchase Agreement 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 Bonds shall be deposited with the Bond Trustee for authentication, and the Bond Trustee is hereby authorized and directed to authenticate the Bonds and, upon the satisfaction of the conditions set forth in Section 2.08 of the Trust Agreement, the Bond Trustee shall deliver the Bonds to the Purchaser against payment therefor.

Section 11. Truist Bank is hereby appointed as the initial Bond Trustee for the Bonds.

Section 12. If the Bonds are converted to a Rate not in a Direct Purchase Period, the Depository Trust Company, New York, New York is hereby appointed as the initial Securities Depository of 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, Secretary, and any Assistant Secretary of the Commission (or any member of the Commission designated by the Chairman) are each hereby 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 Agreement and the Covenant Agreement, including the refunding of the Prior Bonds.

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

Schedule 1

April 1,	Amount	April 1,	Amount
2021	$645,000	2029	$ 920,000
2022	675,000	2030	960,000
2023	705,000	2031	1,005,000
2024	735,000	2032	1,050,000
2025	770,000	2033	1,100,000
2026	805,000	2034	1,145,000
2027	840,000	2035	1,200,000
2028	880,000	2036*	1,255,000

* Maturity

Professional Fees Comparison for
UNC Lenoir Health Care

Professional	Fees Estimated In Preliminary Approval Resolution	Actual (Not to Exceed) Fees
Financial advisor	$25,000	$25,000
Purchaser counsel	40,000	40,000
Bond counsel	60,000	60,000
Corporation counsel	40,000	40,000
Trustee fee	7,000	7,000
Trustee counsel	10,000	10,000
Accountant fee	19,000	19,000

COMMISSION ACTION: *Motion was made to approve the refunding by Dr. Paul Cunningham, seconded by Mr. Joe Crocker, and unanimously approved.*

B. CaroMont Regional Medical Center (Gastonia)……...…...Geary W. Knapp & Jeff Harms

Resolution: The Commission grants preliminary approval to a project for CaroMont Regional Medical Center to provide funds to be used, together with other available funds, to ***construct*** the following:

- New 4-Story Patient Care Tower (146,000 Square Feet)
  - 78 Private Critical Care & Intermediate Care Patient Rooms (Relocated)
    - Built on top of current 2-Story building
    - 6th Floor: Cardiac Intensive Care Nursing Units
    - 5th Floor: Intensive Care Nursing Units
    - 4th Floor: Post-Intensive Care Unit
    - 3rd Floor: Shell space reserved for future growth
    - Each floor contains 26 patient rooms / family support space / centralized nursing stations / administrative areas

- Corridor connecting 4th Floor to main tower

Capital expenditures for new construction shall be included as listed below, all in accordance with a preliminary application, plans and specifications and participation as follows:

ESTIMATED SOURCES OF FUNDS

Principal Amount of Bonds to be Issued	**$129,100,000**

ESTIMATED USES OF FUNDS

Construction costs	$105,100,305
Construction contingency (less than 1% of construction contracts)	1,000,000
Architect's Fees	4,165,000
Architect's Reimbursable	214,150
Moveable equipment	17,265,000
Surveys/Tests/Insurance	195,000
Rating Agency	195,000
Printing Costs	10,000
Underwriter Fee	390,000
Underwriter Counsel	115,000
Bond Counsel	120,000
Corporate Counsel	75,000
Trustee Fee	8,100
Trustee Counsel	4,000
DHSR Review Fee	74,695
Local Government Commission Fee	8,750
Accountant Fee (AUP)	70,000
Financial Advisor Fee	90,000
Total	**$129,100,000**

Tentative approval is given with the understanding that the governing board of CaroMont Regional Medical Center accepts the following conditions:

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

2. Any required certificate of need must be in effect at the time of the issuance of the bonds or notes.

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

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

5. 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%).

6. 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 patients.

7. 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.

8. The borrower will provide the Commission annually a copy of Schedule H of the IRS form 990 to demonstrate community benefits provided by the borrower.

9. 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.

10. All health care facilities and services directly or indirectly owned or controlled by the health care organization, including physician practices, shall be available to Medicare and Medicaid patients with no limitations imposed as a result of the source of reimbursement.

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

*Dr. John Meier conducted the discussion and voting on the Bond Project for CaroMont Health. A presentation was given by Mr. Chris Peek, CEO, Mr. David O'Connor, CFO, and Ms. Shari Reese, Controller. See **Exhibits H & J** for selected application information, bond sale approval form and presentation.*

Remarks were made by Mr. Joe Crocker, Mrs. Kathy Barger, Mr. Bryant Foriest, Dr. Robert Schaaf, Dr. John Fagg, Dr. Paul Cunningham, Dr. Anita Jackson, and Mr. Jeff Harms.

COMMISSION ACTION: *A motion for preliminary approval of the project was made by Mr. Joe Crocker, seconded by Mrs. Eileen Kugler, and unanimously approved with the recusals of Dr. John Fagg, and Dr. Robert Schaaf.*

C. Appalachian Regional Healthcare System (Boone)……..…….Geary W. Knapp & Jeff Harms

Resolution: The Commission grants preliminary approval to a project for Appalachian Regional Health System to provide funds to be used, together with other available funds, to ***construct*** the following:

- New 4-Story Building (103,000 Square Feet) - $71,098,487
  - Relocating 48 beds from main hospital to private rooms
    - 4th Floor: 24 Patient Beds
    - 3rd Floor: 24 Patient Beds

    - 2nd Floor: Operating Suite
    - 1st Floor: Diagnostic Services / Women's Health
- Central Energy Plant - $25,626,262
- Relocation of ICU Suite and Nursery - $3,200,000
- Land Improvements including additional parking - $1,815,895

Capital expenditures for new construction shall be included as listed below, all in accordance with a preliminary application, plans and specifications and participation as follows:

ESTIMATED SOURCES OF FUNDS

Principal Amount of Bonds to be Issued	**$124,585,000**

ESTIMATED USES OF FUNDS

Construction costs	$ 77,574,494
Construction contingency (less than 1% of construction contracts)	775,745
Site Costs	6,087,485
Architect's Fees	6,267,812
Moveable equipment	16,224,810
Amount to prepay Construction Loan	6,800,000
Bond Interest during Construction	9,500,000
Rating Agency	200,000
Printing Costs	10,000
Underwriter Fee	500,000
Underwriter Counsel	115,000
Bond Counsel	125,000
Corporate Counsel	50,000
Trustee Fee	10,000
Trustee Counsel	10,000
DHSR Review Fee	75,904
Local Government Commission Fee	8,750
Accountant Fee (AUP)	100,000
Financial Advisor Fee	150,000
Total	**$124,585,000**

Tentative approval is given with the understanding that the governing board of Appalachian Regional Healthcare System accepts the following conditions:

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

2. Any required certificate of need must be in effect at the time of the issuance of the bonds or notes.

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

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

5. 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%).

6. 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 patients.

7. 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.

8. The borrower will provide the Commission annually a copy of Schedule H of the IRS form 990 to demonstrate community benefits provided by the borrower.

9. 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.

10. All health care facilities and services directly or indirectly owned or controlled by the health care organization, including physician practices, shall be available to Medicare and Medicaid patients with no limitations imposed as a result of the source of reimbursement.

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

*Dr. John Meier conducted the discussion and voting on the Bond Project for Appalachian Regional Health Care. A presentation was given by Chuck Mantooth, CEO. See **Exhibits I** and **K** for selected application information, bond sale approval form, and presentation.*

Remarks were made by Mr. Joe Crocker, Mrs. Eileen Kugler, Mr. Matt Thomas, and Chuck Stafford.

COMMISSION ACTION: *Motion for preliminary approval of the project was made by Dr. Paul Cunningham, seconded by Mrs. Eileen Kugler, and unanimously approved.*

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

A. Rules for Adoption

1. Ambulatory Surgical Center Rules…….Nadine Pfeiffer & Azzie Conley

Readoption of four rules following Periodic Review and the amendment of two rules

- Rules: 10A NCAC 13C.0202, 0203, 0301, 0501, 0702, and .0902
  (See Exhibits C thru C/1)

COMMISSION ACTION: *Motion was made to approve the Ambulatory Surgical Center Rules by Dr. Paul Cunningham, seconded by Mr. Al Lockamy, and unanimously approved.*

2. Hospice Licensing Rules……..……..Nadine Pfeiffer and Cindy Deporter

Readoption of five rules following Periodic Review

- Rules: 10A NCAC 13K .0102, .0401, .0604, .0701, and .1104
  (See Exhibits C/2 thru C/4)

COMMISSION ACTION: *Motion was made to approve the Hospice Licensing Rules by Mr. Joe Crocker, seconded by Mr. Bryant Foriest, and unanimously approved.*

3. Licensing of Nursing Home Rules…….……..Nadine Pfeiffer and Beverly Speroff

Amendment of two rules and repeal of one rule for ventilator assisted care

- Rules: 10A NCAC 13D .2001, .2506, and .3003
  (See Exhibits C/5 thru C/6)

COMMISSION ACTION: *Motion was made to approve the Nursing Home Rules by Mrs. Kathy Barger, seconded by Mr. Joe Crocker, and unanimously approved.*

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

A. Rule for Initiating Rulemaking Approval

1. Emergency Medical Services and Trauma Rules……..…….Nadine Pfeiffer & Tom Mitchell

Amendment of twenty-two rules for education and credentialing.

- Rules: 10A NCAC 13P .0101, .0102, .0222, .0501, .0502, .0504, .0507, .0508, .0510, .0512, .0601, .0602, .0904, .0905, .1101, .1401, .1403, .1404, .1405, .1505, .1507, and .1511
  (See Exhibits D thru D/2)

COMMISSION ACTION: *Motion was made to approve the Emergency Medical Services and Trauma Rules by Dr. Paul Cunningham, seconded by Dr. Robert Schaaf, and unanimously approved.*

2. Adult Care Home/Family Care Rules……...…….Nadine Pfeiffer and Megan Lamphere

Readoption of four rules following Periodic Review and amendment of one rule – Phase 2

- Rules: 10A NCAC 13F .0403, .0406; 10A NCAC 13G .0402, .0403, and .0405
  (See Exhibits D/3 thru D/5)

COMMISSION ACTION: *Motion was made to approve the Adult Care Home and Family Care Rules by Mr. Joe Crocker, seconded by Mrs. Eileen Kugler, and unanimously approved.*

XII. Adoption of 2021 Medical Care Commission Meeting Dates (Action Item)……...…….Dr. John Meier

February 11-12, 2021
May 13-14, 2021
August 12-13, 2021
November 4-5, 2021

COMMISSION ACTION: *Motion to approve the Commission Meeting Dates for 2021 was made by Mr. Joe Crocker, seconded by Mrs. Eileen Kugler, and unanimously approved.*

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 12, 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 between this date and February 12, 2021.

COMMISSION ACTION: *Motion was made to authorize the Executive Committee to approve projects involving the refunding of existing Commission debt between this date and February 12, 2021 was made by Mrs. Kathy Barger, seconded by Mr. Joe Crocker, and unanimously approved.*

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

In accordance with 10A NCAC 13A.0101, the NCMCC's Chairman shall appoint two members to the Executive Committee to serve for a term of two years or until expiration of his/her regularly appointed term. No member of the Executive Committee, except the Chairman and Vice-Chairman, shall serve more than two two-year terms in succession. The terms are scheduled to expire 12/31/2022.

COMMISSION ACTION: *Dr. John Meier appointed Mrs. Eileen Kugler and Mrs. Sally Cone to serve a two year term on the Executive Committee (ending 12/31/2022) as the Chairman's appointed members.*

XV. Election of Vice-Chairman (Action Item)……...…...……..Dr. John Meier

In accordance with N.C.G.S. § 143B-168, the NCMCC shall elect from the members a Vice-Chairman to serve for a term of two years (ending 12/31/2022) or until the expiration of his/her regularly appointed term.

Dr. John Meier nominated Mr. Joe Crocker to serve another two year term as Vice-Chairman (ending 12/31/202022). No other nominations were received for the Vice-Chairman position.

COMMISSION ACTION: *Mr. Joe Crocker was unanimously elected to serve a two year term as the Vice-Chairman (ending 12/31/2022).*

XVI. Compliance Policy Adoption.....Geary W. Knapp

See Exhibit E for Compliance Policy

COMMISSION ACTION: *Motion was made to accept the new Compliance Policy by Mr. Bryant Foriest, seconded by Mr. Joe Crocker, and unanimously approved.*

XVII. Meeting Adjournment– There being no further business the meeting was adjourned at 11:35 a.m.

Respectfully submitted,

Geary W. Knapp, JD, CPA

EXHIBIT A/1

STATE OF NORTH CAROLINA
DEPARTMENT OF HEALTH AND HUMAN SERVICES

MEDICAL CARE COMMISSION EMERGENCY TELECONFERENCE MEETING
DIVISION OF HEALTH SERVICE REGULATION
809 RUGGLES DRIVE
RALEIGH, NORTH CAROLINA 27603
CONFERENCE ROOM #026A – EDGERTON BUILDING

Teams Video Conference Link
Click here to join the meeting

Or

Dial-In Number: 1-984-204-1487 / Passcode: 23608305#

WEDNESDAY, DECEMBER 9, 2020
11:30 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 Eileen C. Kugler, RN, MSN, MPH, FNP Albert F. Lockamy, Jr., RPh Ashley H. Lloyd, D.D.S. Karen E. Moriarty Stephen T. Morton	Anita L. Jackson, M.D. 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 Nadine Pfeiffer, Rules Review Manager, DHSR Jeff Harms, Acting Chief, DHSR Construction Section Megan Lamphere, Chief, Adult Care Licensure Section Libby Kinsey, Assistant Chief, Adult Care Licensure Section Tichina Hamer, Director of Programs, Adult Care Licensure Section Bethany Burgon, Attorney General's Office Crystal Watson-Abbott, Auditor, MCC Kathy Larrison, Auditor, MCC Alice Creech, Executive Assistant, MCC	

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** (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

Temporary rulemaking for infection prevention policies and procedures, communicable disease reporting due to COVID-19. (Four Rules)

- 10A NCAC 13F .1801, and .1802, 10A NCAC 13G .1701, and .1702 **(See Exhibits A thru A/3)**

COMMISSION ACTION: Motion was made to approve temporary rulemaking for Adult Care Home & Family Care Home Rules with wording changes to 10A NCAC 13F .1801 and 10A NCAC 13G .1701 (highlighted in **Exhibit A/4** and **Exhibit A/5**) by Dr. Paul Cunningham, seconded by Mr. Joe Crocker, and unanimously approved.

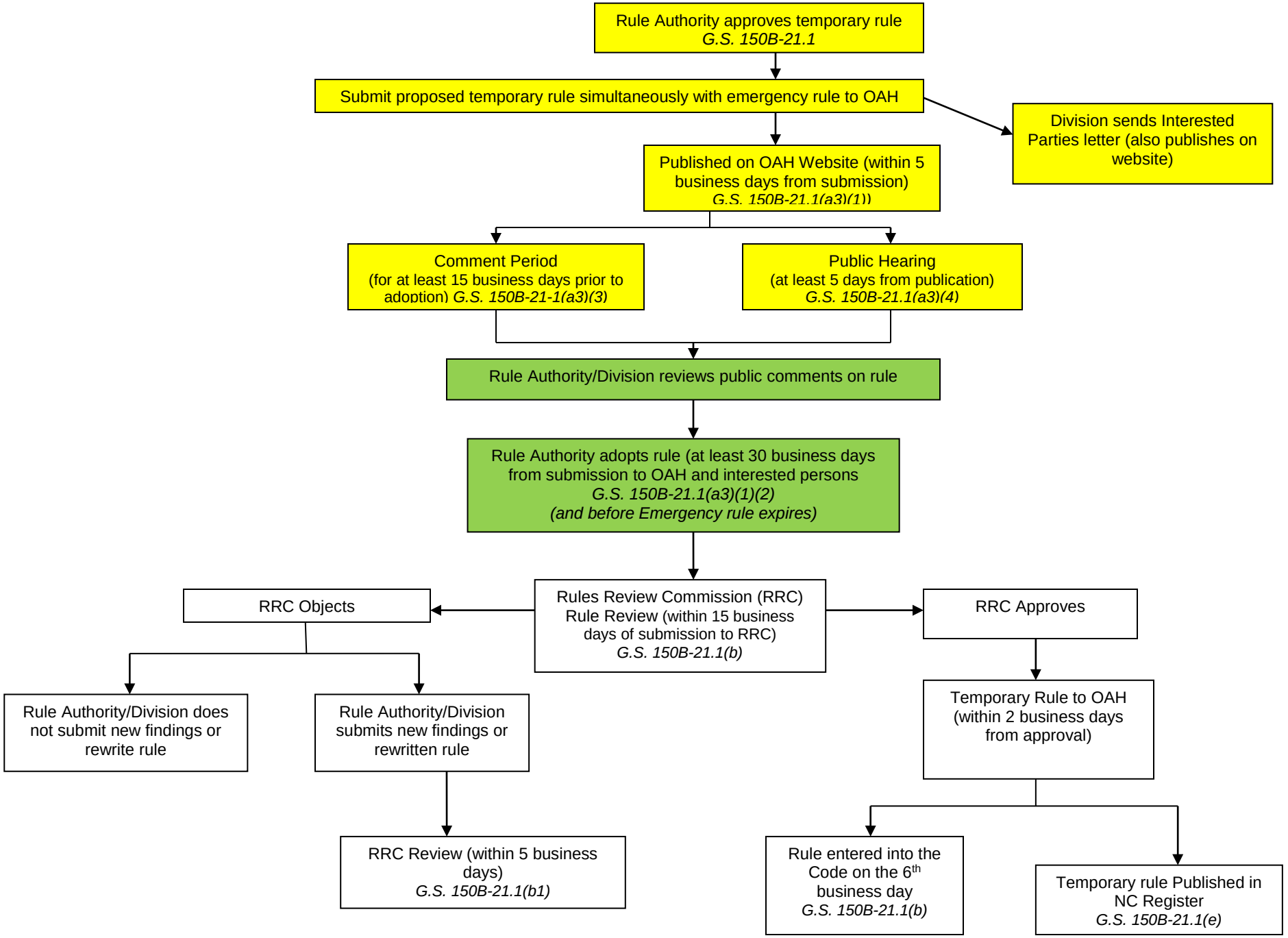
V. **Meeting Adjournment** – There being no further business, the meeting was adjourned at 12:25 p.m.

Respectfully submitted,

Geary W. Knapp, JD, CPA
Assistant Secretary

Temporary Rulemaking Process

Exhibit A



10A NCAC 13F .1801 is adopted under temporary procedures with changes as follows:

SECTION .1800 - INFECTION PREVENTION AND CONTROL

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

(a) In accordance with Rule 13F .1211 of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement a comprehensive 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 ensure implementation of the facility's IPCP, related policies and procedures, and guidance or directives issued by the CDC, the local health department, and/or the North Carolina Department of Health and Human Services.~~

~~(c)~~ (b) The facility shall assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines on infection control and addresses ~~at least~~ 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);
   (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 13F .1802 of this Section:

(3) Resident care when there is suspected or confirmed communicable disease in the facility, including, when indicated, isolation of infected residents, limiting or stopping group activities and communal dining, and based on the mode of transmission, use of source control as tolerated by the residents. Source control includes the use of face coverings for residents when the mode of transmission is through a respiratory pathogen:

(4) Procedures for screening visitors to the facility and criteria for restricting visitors who exhibit signs of illness, as well as posting signage for visitors regarding screening and restriction procedures;

(5) Procedures for screening facility staff and criteria for restricting staff who exhibit signs of illness from working;

(6) Procedures and strategies for addressing staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak:

(7) The annual review of the facility's IPCP and update of the IPCP as necessary; and

(8) a process for updating policies and procedures to reflect guidelines and recommendations by the CDC, local health department, and North Carolina Department of Health and Human Services (NCDHHS) during a public health emergency as declared by the United States and that applies to North Carolina or a public health emergency declared by the State of North Carolina.

(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 by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility.

(d) In accordance with Rule 13F .1211 of this Subchapter, the facility shall ensure all staff are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs ~~(c)(1)~~ (b)(1) through (5) of this Rule. Training on Parts ~~(c)(1)(D)~~ (b)(1)(D) and (E) of this Rule shall include hands-on demonstration by a trained instructor and return demonstration by the staff person.

(e) The facility shall ensure that, prior to administration, all staff responsible for administering tests to residents for the diagnosis of a communicable disease or condition shall be trained on the proper use of testing devices and materials consistent with manufacturer's specifications.

(f) The facility shall ensure staff employed in a management or supervisory role in the facility are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs ~~(c)(1)~~ (b)(1) through (6) of this Rule.

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

(h) The ~~facility shall ensure that the IPCP is incorporated into the~~ facility's emergency preparedness disaster plan ~~and updated as needed to~~ shall address any emerging infectious disease threats to protect the residents during a shelter-in-place or emergency evacuation event.

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

10A NCAC 13F .1802 is adopted under temporary procedures with changes 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 Rules 10A NCAC 41A .0101 and 10A NCAC 41A .0102(a)(1) through (a)(3), including subsequent amendments and editions.

~~(b) The facility shall implement recommendations to the greatest extent practicable provided by the local health department in response to a suspected or confirmed communicable disease case or condition or communicable disease outbreak.~~

~~(c)~~ (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, or one or more confirmed cases of COVID-19 among any resident or staff person. 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.~~ 2020;
Temporary Adoption Eff. December 30, 2020.

10A NCAC 13G .1701 is adopted under temporary procedures with changes as follows:

SECTION .1700 - INFECTION PREVENTION AND CONTROL

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

(a) In accordance with Rule 13G .1211 of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement a comprehensive 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 ensure implementation of the facility's IPCP, related policies and procedures, and guidance or directives issued by the CDC, the local health department, and/or the North Carolina Department of Health and Human Services.~~

~~(c)~~ (b) The facility shall assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines on infection control and addresses ~~at least~~ 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);
   (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 13G .1702 of this Section:

(3) Resident care when there is suspected or confirmed communicable disease in the facility, including, when indicated, isolation of infected residents, limiting or stopping group activities and communal dining, and based on the mode of transmission, use of source control as tolerated by the residents. Source control includes the use of face coverings for residents when the mode of transmission is through a respiratory pathogen:

(4) Procedures for screening visitors to the facility and criteria for restricting visitors who exhibit signs of illness, as well as posting signage for visitors regarding screening and restriction procedures;

(5) Procedures for screening facility staff and criteria for restricting staff who exhibit signs of illness from working;

(6) Procedures and strategies for addressing staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak:

(7) The annual review of the facility's IPCP and update of the IPCP as necessary; and

(8) a process for updating policies and procedures to reflect guidelines and recommendations by the CDC, local health department, and North Carolina Department of Health and Human Services (NCDHHS) during a public health emergency as declared by the United States and that applies to North Carolina or a public health emergency declared by the State of North Carolina.

(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 by the NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility.

(d) In accordance with Rule 13G .1211 of this Subchapter, the facility shall ensure all staff are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs ~~(c)(1)~~ (b)(1) through (5) of this Rule. Training on Parts ~~(c)(1)(D)~~ (b)(1)(D) and (E) of this Rule shall include hands-on demonstration by a trained instructor and return demonstration by the staff person.

(e) The facility shall ensure that, prior to administration, all staff responsible for administering tests to residents for the diagnosis of a communicable disease or condition shall be trained on the proper use of testing devices and materials consistent with manufacturer's specifications.

(f) The facility shall ensure staff employed in a management or supervisory role in the facility are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs ~~(c)(1)~~ (b)(1) through (6) of this Rule.

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

(h) The ~~facility shall ensure that the IPCP is incorporated into the~~ facility's emergency preparedness disaster plan ~~and updated as needed to~~ shall address any emerging infectious disease threats to protect the residents during a shelter-in-place or emergency evacuation event.

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

10A NCAC 13G .1702 is adopted under temporary procedures with changes 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 Rules 10A NCAC 41A .0101 and 10A NCAC 41A .0102(a)(1) through (a)(3), including subsequent amendments and editions.

~~(b) The facility shall implement recommendations to the greatest extent practicable provided by the local health department in response to a suspected or confirmed communicable disease case or condition or communicable disease outbreak.~~

~~(c)~~ (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, or one or more confirmed cases of COVID-19 among any resident or staff person. 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.~~ 2020;
Temporary Adoption Eff. December 30, 2020.

Adult Care Home & Family Care Home Temporary Rules Public Comments
10A NCAC 13F .1801 & .1802; 10A NCAC 13G .1701 & .1702
Comment Period 10/23/20 – 11/16/20

Introduction:

Three individuals submitted comments during the public comment period on the temporary adoption rules 10A NCAC 13F .1801 & .1802; 10A NCAC 13G .1701 & .1702. Of these comments, one person made statements during the public hearing conducted on November 4, 2020. The comments were submitted by representatives from the following: N.C. Senior Living Association, and the N.C. Assisted Living Association (public hearing and written comments. A summary of all comments received on this rule is below:

1) Listing of Comments Received and Agency's Consideration of Comments for Rule 13F .1801 – Infection Prevention And Control Policies And Procedures:

Commenter	Comment Summary
1) N.C. Senior Living Association (NCSLA) (public hearing comment)	Paragraph (b) has three different agencies, the CDC, the local health department, and North Carolina DHHS that the providers must keep track of for directives, policies, and guidance issued for everything providers do. To ask adult care homes to do this and to stay on top of this all the time is setting them up for failure because it's an impossible task. Sometimes the directives and guidance issued by the CDC, the local health department and the North Carolina Department of Health and Human Services conflict with each other. When that happens what does a provider do? The Agency should specifically state which directives issued by the CDC and maybe NC DHHS that providers are to comply with. The Agency should do due diligence to determine if there's any conflict between those different agencies before putting this in rule. Our members say it depends on the health department from which county you're in on what kind of instructions, guidance, or directives you get. It's all over the map. One county will give directives one way, another county will give directives another way in terms of testing, how to respond to the pandemic, etc. It will be very confusing for providers to stay on top of the guidance and directives issued by these three government agencies to decide what's coming out, reconcile conflicting ones, and decide which one to go with, and then also put them into policies procedures, and training staff on them. It's an impossible task. Request: the Agency should explicitly state in the rule which guidance or directives by each of these bodies provider compliance is expected and to be certain of no conflicts between the guidance and directives of those different governmental agencies.
2) N.C. Senior Living Association (NCSLA)	Paragraph (b) creates the same type of ambiguity that providers experienced when cited by DHSR for not following guidelines and recommendations from the CDC, DHHS, and the local health departments.

Commenter	Comment Summary
(written comment)	Requiring providers to constantly check, reconcile differences, revise policies and procedures, and train staff based on guidance or directives issued by three agencies is difficult, if not impossible to achieve. Following local health department guidance or directives depends on which county your facility happens to be located. The direction varies widely by county during the pandemic. Request: Commission remove any reference to local health departments in the proposed rules, explicitly tell providers in rule which specific CDC or DHHS guidance or directives to follow, and to focus guidance and directives that are unlikely to change during the time the temporary rules are in effect. With input from Division of Public Health and others in DHHS, easier rules for providers to navigate and comply can be generated.

DHSR Response to Comments Above:

The agency has worked collaboratively with stakeholders (including the associations that provided comment above) to clarify the language in (b), which is now (c) in rule 13F .1801. The new language clarifies that a facility should follow CDC guidance and its own infection control policies and procedures unless more specific guidance or directives have been issued by NCDHHS or the local health department, in which case, the facility shall implement the specific guidance and directives. CDC guidance is issued nationally and serves as a basis, or foundation, for infection prevention and control in long term care facilities. However, it can be reasonably expected that states or local health departments may issue specific guidance or directives based on the special circumstances within each state, county, or even each facility.

In regard to the comments that the associations believe that the temporary rules should not become permanent rules, these comments are not relevant to the current proceedings. The issue before the agency at this time is the adoption of temporary rules to take the place of the emergency rules that will expire in January 2020. While the agency does intend to pursue permanent rulemaking for these rules, that is a separate process during which the agency will continue to engage all relevant stakeholders and will include another public comment period and opportunities to make changes to the rules. Additionally, the permanent rulemaking process will include an analysis of the fiscal impact of the rules on all relevant parties. For now, both associations have purported to the agency that they are in support of temporary rules and the agency has been transparent throughout the temporary rulemaking process and made several modifications to the rules based on their feedback.

The agency believes that it is imperative for the health and safety of residents in adult care homes, not just during a pandemic but for everyday operations, that facilities have clear requirements for the development and implementation of effective infection prevention and control practices in the facility. Adult care home residents are increasingly older, more medically complex, and at a higher risk of complications due to various infectious diseases. Residing in a congregate living setting also increases their risk. Additionally, adult care homes are typically not staffed with clinical professionals who have the education and training to understand, recognize and evaluate situations that pose significant risks to residents. The rules before the Medical Care Commission seek to strengthen the existing rules and statues for infection prevention and control, which are currently vague and lack specific guidance to facilities on preventing communicable diseases. Equally important, the new rules set forth requirements for reporting suspected outbreaks to the appropriate agency, as well as informing residents, their

families, and staff when an outbreak occurs. The temporary rules before the Commission, after consideration and incorporation of feedback from stakeholders, are recommended by the agency for final adoption.

2) Listing of Comments Received and Agency's Consideration of Comments for Rule 13G .1701 – Infection Prevention And Control Policies And Procedures:

Commenter	Comment Summary
1) N.C. Senior Living Association (NCSLA) (public hearing comment)	Paragraph (b) has three different agencies, the CDC, the local health department, and North Carolina DHHS that the providers must keep track of for directives, policies, and guidance issued for everything providers do. To ask adult care homes to do this and to stay on top of this all the time is setting them up for failure because it's an impossible task. Sometimes the directives and guidance issued by the CDC, the local health department and the North Carolina Department of Health and Human Services conflict with each other. When that happens what does a provider do? The Agency should specifically state which directives issued by the CDC and maybe NC DHHS that providers are to comply with. The Agency should do due diligence to determine if there's any conflict between those different agencies before putting this in rule. Our members say it depends on the health department from which county you're in on what kind of instructions, guidance, or directives you get. It's all over the map. One county will give directives one way, another county will give directives another way in terms of testing, how to respond to the pandemic, etc. It will be very confusing for providers to stay on top of the guidance and directives issued by these three government agencies to decide what's coming out, reconcile conflicting ones, and decide which one to go with, and then also put them into policies procedures, and training staff on them. It's an impossible task. Request: the Agency should explicitly state in the rule which guidance or directives by each of these bodies provider compliance is expected and to be certain of no conflicts between the guidance and directives of those different governmental agencies.
2) N.C. Senior Living Association (NCSLA) (written comment)	Paragraph (b) creates the same type of ambiguity that providers experienced when cited by DHSR for not following guidelines and recommendations from the CDC, DHHS, and the local health departments. Requiring providers to constantly check, reconcile differences, revise policies and procedures, and train staff based on guidance or directives issued by three agencies is difficult, if not impossible to achieve. Following local health department guidance or directives depends on which county your facility happens to be located. The direction varies widely by county during the pandemic.

Commenter	Comment Summary
	Request: Commission remove any reference to local health departments in the proposed rules, explicitly tell providers in rule which specific CDC or DHHS guidance or directives to follow, and to focus guidance and directives that are unlikely to change during the time the temporary rules are in effect. With input from Division of Public Health and others in DHHS, easier rules for providers to navigate and comply can be generated.

DHSR Response to Comments Above:

The agency has worked collaboratively with stakeholders (including the associations that provided comment above) to clarify the language in (b), which is now (c) in rule 13G .1701. The new language clarifies that a facility should follow CDC guidance and its own infection control policies and procedures unless more specific guidance or directives have been issued by NCDHHS or the local health department, in which case, the facility shall implement the specific guidance and directives. CDC guidance is issued nationally and serves as a basis, or foundation, for infection prevention and control in long term care facilities. However, it can be reasonably expected that states or local health departments may issue specific guidance or directives based on the special circumstances within each state, county, or even each facility.

In regard to the comments that the associations believe that the temporary rules should not become permanent rules, these comments are not relevant to the current proceedings. The issue before the agency at this time is the adoption of temporary rules to take the place of the emergency rules that will expire in January 2020. While the agency does intend to pursue permanent rulemaking for these rules, that is a separate process during which the agency will continue to engage all relevant stakeholders and will include another public comment period and opportunities to make changes to the rules. Additionally, the permanent rulemaking process will include an analysis of the fiscal impact of the rules on all relevant parties. For now, both associations have purported to the agency that they are in support of temporary rules and the agency has been transparent throughout the temporary rulemaking process and made several modifications to the rules based on their feedback.

The agency believes that it is imperative for the health and safety of residents in family care homes, not just during a pandemic but for everyday operations, that facilities have clear requirements for the development and implementation of effective infection prevention and control practices in the facility. Family care home residents are increasingly older, more medically complex, and at a higher risk of complications due to various infectious diseases. Residing in a congregate living setting also increases their risk. Additionally, family care homes are typically not staffed with clinical professionals who have the education and training to understand, recognize and evaluate situations that pose significant risks to residents. The rules before the Medical Care Commission seek to strengthen the existing rules and statues for infection prevention and control, which are currently vague and lack specific guidance to facilities on preventing communicable diseases. Equally important, the new rules set forth requirements for reporting suspected outbreaks to the appropriate agency, as well as informing residents, their families, and staff when an outbreak occurs. The temporary rules before the Commission, after consideration and incorporation of feedback from stakeholders, are recommended by the agency for final adoption.

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

Commenter	Comment Summary
1) N.C. Senior Living Association (NCSLA) (public hearing comment)	Emergency rules were effective 10/23/20 due to the coronavirus. The Agency is moving to make temporary rules using the emergency rules' basis for that. Understands the rules were in response to the coronavirus pandemic and why doing temporary rules. But would expect the temporary to expire and not become permanent rules in any way. Reason being these rules were to address the coronavirus pandemic and its effect on ACHs and FCHs. These rules have a significant financial impact for facilities to develop the policies procedures, implement those, train staff on them, etc. To have these as temporary rules, or even before it could ever be considered for permanent rule, a lot of discussion and due diligence on the part of the Agency is needed regarding the fiscal impact and whether facilities can even comply with these rules.
2) N.C. Assisted Living Association (NCALA)	Rules would impose permanent infection control procedures on NC 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 because of the pandemic. We do not support these same rules becoming permanent rules 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. We support 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. We believe permanent rules should be developed as quickly as possible, but also believe sufficient time should be dedicated to the development of the rules and with participation of affected stakeholders.
3) N.C. Senior Living Association (NCSLA) (written comment)	DHSR and the Commission are in the process of making the emergency infection control rules as temporary rules. The emergency rules were passed in response to COVID-19, and it appears DHSR and Commission are on track to make permanent infection control rules. Our association together with NCALA, worked with DHSR in October when the rules were first being considered. We appreciate the need for rules to address certain standards for providers to protect residents and staff during the pandemic. We do not support making these rules permanent due to the increased costs of compliance, especially for ACH and FCH receiving fixed public funding from state/county special assistance for room and board and Medicaid for personal care services. Without increases in public reimbursement, many facilities receiving funding from public sources (majority of facilities), would be set up for failure. Prior to the pandemic, infection control

Commenter	Comment Summary
	statutes and rules were in place for ACH and FCH such as G.S. 131D-4.4A, 10A NCAC 13F .1004(n) and 10A NCAC 13G .1004(n), and 10A NCAC 13F .1211(a)(4) and 10A NCAC 13G .1211(a)(4). The above rules were working well for ACH and FCH prior to the pandemic and continue to work well. If DHSR and the Commission want to add additional infection control regulatory requirements as permanent rules, it needs to be done after the pandemic has ended, not in response to the pandemic, and with a complete and thorough fiscal impact evaluation before being approved. The emergency and temporary rules were in response, in part, to our concern that DHSR was citing facilities during the pandemic for not complying with CDC, DHHS, and local health department guidelines and recommendations. These citations not only lacked authority, but was seen as ambiguous and unreasonable since the guidelines and recommendations continue to change and evolve as the pandemic has unfolded. DHSR determined emergency rules were needed. We believe that was the correct decision to provide further requirements for providers during the pandemic; however, the developed rules and the temporary rules fall short in several areas.

DHSR Response to Comments Above:

The agency has worked collaboratively with stakeholders (including the associations that provided comment above) to clarify the language in (b), which is now (c) in rules 13F .1801 and 13G .1701. The new language clarifies that a facility should follow CDC guidance and its own infection control policies and procedures unless more specific guidance or directives have been issued by NCDHHS or the local health department, in which case, the facility shall implement the specific guidance and directives. CDC guidance is issued nationally and serves as a basis, or foundation, for infection prevention and control in long term care facilities. However, it can be reasonably expected that states or local health departments may issue specific guidance or directives based on the special circumstances within each state, county, or even each facility.

In regard to the comments that the associations believe that the temporary rules should not become permanent rules, these comments are not relevant to the current proceedings. The issue before the agency at this time is the adoption of temporary rules to take the place of the emergency rules that will expire in January 2020. While the agency does intend to pursue permanent rulemaking for these rules, that is a separate process during which the agency will continue to engage all relevant stakeholders and will include another public comment period and opportunities to make changes to the rules. Additionally, the permanent rulemaking process will include an analysis of the fiscal impact of the rules on all relevant parties. For now, both associations have purported to the agency that they are in support of temporary rules and the agency has been transparent throughout the temporary rulemaking process and made several modifications to the rules based on their feedback.

The agency believes that it is imperative for the health and safety of residents in adult care homes, not just during a pandemic but for everyday operations, that facilities have clear requirements for the development and implementation of effective infection prevention and control practices in the facility. Adult care home residents are increasingly older, more medically complex, and at a higher risk of complications due to various infectious diseases. Residing in a congregate living setting also increases their risk. Additionally, adult care homes are typically not staffed with clinical professionals who have the education and training to

understand, recognize and evaluate situations that pose significant risks to residents. The rules before the Medical Care Commission seek to strengthen the existing rules and statues for infection prevention and control, which are currently vague and lack specific guidance to facilities on preventing communicable diseases. Equally important, the new rules set forth requirements for reporting suspected outbreaks to the appropriate agency, as well as informing residents, their families, and staff when an outbreak occurs. The temporary rules before the Commission, after consideration and incorporation of feedback from stakeholders, are recommended by the agency for final adoption.

10A NCAC 13G .1701 is adopted under temporary procedures with changes as follows:

SECTION .1700 - INFECTION PREVENTION AND CONTROL

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

(a) In accordance with Rule 13G .1211 of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement a comprehensive 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 ensure implementation of the facility's IPCP, related policies and procedures, and guidance or directives issued by the CDC, the local health department, and/or the North Carolina Department of Health and Human Services.~~

~~(c)~~ (b) The facility shall assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines on infection control and addresses ~~at least~~ 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);
   (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 13G .1702 of this Section:

(3) Resident care when there is suspected or confirmed communicable disease in the facility, including, when indicated, isolation of infected residents, limiting or stopping group activities and communal dining, and based on the mode of transmission, use of source control as tolerated by the residents. Source control includes the use of face coverings for residents when the mode of transmission is through a respiratory pathogen:

(4) Procedures for screening visitors to the facility and criteria for restricting visitors who exhibit signs of illness, as well as posting signage for visitors regarding screening and restriction procedures;

(5) Procedures for screening facility staff and criteria for restricting staff who exhibit signs of illness from working;

(6) Procedures and strategies for addressing staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak:

(7) The annual review of the facility's IPCP and update of the IPCP as necessary; and

(8) a process for updating policies and procedures to reflect guidelines and recommendations by the CDC, local health department, and North Carolina Department of Health and Human Services (NCDHHS) during a public health emergency as declared by the United States and that applies to North Carolina or a public health emergency declared by the State of North Carolina.

(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 NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility.

(d) In accordance with Rule 13G .1211 of this Subchapter, the facility shall ensure all staff are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs ~~(c)(1)~~ (b)(1) through (5) of this Rule. Training on Parts ~~(c)(1)(D)~~ (b)(1)(D) and (E) of this Rule shall include hands-on demonstration by a trained instructor and return demonstration by the staff person.

(e) The facility shall ensure that, prior to administration, all staff responsible for administering tests to residents for the diagnosis of a communicable disease or condition shall be trained on the proper use of testing devices and materials consistent with manufacturer's specifications.

(f) The facility shall ensure staff employed in a management or supervisory role in the facility are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs ~~(c)(1)~~ (b)(1) through (6) of this Rule.

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

(h) The ~~facility shall ensure that the IPCP is incorporated into the~~ facility's emergency preparedness disaster plan ~~and updated as needed to~~ shall address any emerging infectious disease threats to protect the residents during a shelter-in-place or emergency evacuation event.

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

10A NCAC 13F .1801 is adopted under temporary procedures with changes as follows:

SECTION .1800 - INFECTION PREVENTION AND CONTROL

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

(a) In accordance with Rule 13F .1211 of this Subchapter and G.S. 131D-4.4A(b)(1), the facility shall establish and implement a comprehensive 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 ensure implementation of the facility's IPCP, related policies and procedures, and guidance or directives issued by the CDC, the local health department, and/or the North Carolina Department of Health and Human Services.~~

~~(c)~~ (b) The facility shall assure the following policies and procedures are established and implemented consistent with the federal CDC published guidelines on infection control and addresses ~~at least~~ 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);
   (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 13F .1802 of this Section:

(3) Resident care when there is suspected or confirmed communicable disease in the facility, including, when indicated, isolation of infected residents, limiting or stopping group activities and communal dining, and based on the mode of transmission, use of source control as tolerated by the residents. Source control includes the use of face coverings for residents when the mode of transmission is through a respiratory pathogen:

(4) Procedures for screening visitors to the facility and criteria for restricting visitors who exhibit signs of illness, as well as posting signage for visitors regarding screening and restriction procedures;

(5) Procedures for screening facility staff and criteria for restricting staff who exhibit signs of illness from working;

(6) Procedures and strategies for addressing staffing issues and ensuring staffing to meet the needs of the residents during a communicable disease outbreak:

(7) The annual review of the facility's IPCP and update of the IPCP as necessary; and

(8) a process for updating policies and procedures to reflect guidelines and recommendations by the CDC, local health department, and North Carolina Department of Health and Human Services (NCDHHS) during a public health emergency as declared by the United States and that applies to North Carolina or a public health emergency declared by the State of North Carolina.

(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 NCDHHS or local health department, the specific guidance or directives shall be implemented by the facility.

(d) In accordance with Rule 13F .1211 of this Subchapter, the facility shall ensure all staff are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs ~~(c)(1)~~ (b)(1) through (5) of this Rule. Training on Parts ~~(c)(1)(D)~~ (b)(1)(D) and (E) of this Rule shall include hands-on demonstration by a trained instructor and return demonstration by the staff person.

(e) The facility shall ensure that, prior to administration, all staff responsible for administering tests to residents for the diagnosis of a communicable disease or condition shall be trained on the proper use of testing devices and materials consistent with manufacturer's specifications.

(f) The facility shall ensure staff employed in a management or supervisory role in the facility are trained within 30 days of hire and annually on the policies and procedures listed in Subparagraphs ~~(c)(1)~~ (b)(1) through (6) of this Rule.

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

(h) The ~~facility shall ensure that the IPCP is incorporated into the~~ facility's emergency preparedness disaster plan ~~and updated as needed to~~ shall address any emerging infectious disease threats to protect the residents during a shelter-in-place or emergency evacuation event.

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

NC Medical Care Commission

Quarterly Report on **Outstanding Debt** (End: 2nd Quarter FYE 2021)

Program Measures	FYE 2020 Ending: 6/30/2020	FYE 2021 Ending: 12/31/2020
Outstanding Debt	**$5,694,191,427**	**$5,415,626,442**
Outstanding Series	**125**[1]	**126**[1]

Detail of Program Measures	Ending: 6/30/2020	Ending: 12/31/2020
Outstanding Debt per Hospitals and Healthcare Systems	$4,496,197,271	$3,936,302,001
Outstanding Debt per CCRCs	$1,141,594,156	$1,423,869,441
Outstanding Debt per Other Healthcare Service Providers	$56,400,000	$55,455,000
Outstanding Debt Total	**$5,694,191,427**	**$5,415,626,442**
Outstanding Series per Hospitals and Healthcare Systems	73	67
Outstanding Series per CCRCs	50	57
Outstanding Series per Other Healthcare Service Providers	2	2
Series Total	**125**	**126**
Number of Hospitals and Healthcare Systems with Outstanding Debt	17	15
Number of CCRCs with Outstanding Debt	17	17
Number of Other Healthcare Service Providers with Outstanding Debt	1	1
Facility Total	35	33

Note 1: For FYE 2021, NCMCC has closed 13 **Bond Series**. Out of the 13 closed Bond Series: 2 were conversions, 9 were new money projects, 2 were refundings. The Bond Series outstanding from FYE 2020 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)

Exhibit B (Outstanding Balance)

NC Medical Care Commission

Quarterly Report on **History** of NC MCC Finance Act Program (End: 2nd Quarter FYE 2021)

Program Measures	FYE 2020 Ending: 6/30/2020	FYE 2021 Ending: 12/31/2020
Total PAR Amount of Debt Issued	**$26,550,874,158**	**$27,105,067,159**
Total Project Debt Issued (excludes refunding/conversion proceeds)[1]	**$12,940,409,253**	**$13,252,762,254**
Total Series Issued	**643**	**656**

Detail of Program Measures	Ending: 6/30/2020	Ending: 12/31/2020
PAR Amount of Debt per Hospitals and Healthcare Systems	$21,575,249,855	$21,817,089,855
PAR Amount of Debt per CCRCs	$4,601,329,073	$4,913,682,074
PAR Amount of Debt per Other Healthcare Service Providers	$374,295,230	$374,295,230
Par Amount Total	**$26,550,874,158**	**$27,105,067,159**
Project Debt per Hospitals and Healthcare Systems	$10,167,759,674	$10,167,759,674
Project Debt per CCRCs	$2,525,635,665	$2,837,988,666
Project Debt per Other Healthcare Service Providers	$247,013,915	$247,013,915
Project Debt Total	**$12,940,409,253**	**$13,252,762,254**
Series per Hospitals and Healthcare Systems	404	408
Series per CCRCs	200	209
Series per Other Healthcare Service Providers	39	39
Series Total	**643**	**656**
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.

EXHIBIT B-1

STATE OF NORTH CAROLINA
NORTH CAROLINA DEPARTMENT OF HEALTH AND HUMAN SERVICES

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

MINUTES

CALLED MEETING OF THE EXECUTIVE COMMITTEE OF THE COMMISSION
CONFERENCE TELEPHONE MEETING ORIGINATING
FROM THE OFFICES OF THE COMMISSION
January 21, 2021
11:30 A.M.

Via Microsoft Teams: Click here to join the meeting
OR
Dial-IN: 1-984-204-1487 / Passcode: 547 899 63#

Members of the Commission Present:

Dr. John J. Meier, IV, Chairman
Joseph D. Crocker, Vice-Chairman
Sally B. Cone
Linwood B. Hollowell, III
Eileen C. Kugler, RN, MSN, MPH, FNP
Albert F. Lockamy, RPh
Jeffrey S. Wilson

Members of Staff Present:

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

Others Present:

Paul Billow, Womble Bond Dickinson (US) LLP
Jon Mize, Womble Bond Dickinson (US) LLP
David O'Connor, CaroMont Health
Shari Reese, CaroMont Health
Phil Delvecchio, Bank of America Merrill Lynch
Charles Stafford, Ponder & Co.

1. Purpose of Meeting

To consider a resolution authorizing the sale and issuance of bonds, the proceeds of which will be loaned to Gaston Memorial Hospital, Incorporated, CaroMont Health Services, Inc., and CaroMont Health, Inc.

2. Series Resolution Authorizing the Issuance of $40,950,000 North Carolina Medical Care Commission Hospital Revenue Bonds (CaroMont Health), Series 2021A (the "Series 2021A Bonds") and $64,310,000 North Carolina Medical Care Commission Hospital Revenue Bonds (CaroMont Health), Series 2021B (the "Series 2021B Bonds" and, together with the Series 2021A Bonds, the "Bonds").

Executive Committee Action: Motion was made to approve the resolution by Mr. Joe Crocker, seconded by Mrs. Eileen Kugler, and unanimously approved with the recusal of Dr. John Meier.

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, CaroMont Health, Inc., Gaston Memorial Hospital, Incorporated and CaroMont Health Services, Inc. (collectively, the "Borrowers") are each a private, nonprofit corporation duly incorporated and validly existing under and by virtue of the laws of the State of North Carolina which own and operate, by themselves and through their controlled affiliates, various health care facilities; and

WHEREAS, the Borrowers have made application to the Commission for a loan of the proceeds of the Bonds to be made to the Borrowers, for the purpose of providing funds, together with any other available funds, to (a) pay or reimburse the costs of acquiring, constructing and equipping certain hospital facilities and equipment, including, without limitation, an approximately 146,000 square foot, four-story patient tower on the main campus of CaroMont Regional Medical Center in Gastonia, North Carolina (the "Project"), and (b) pay the fees and expenses incurred in connection with the sale and issuance of the Bonds; and

WHEREAS, the Commission has, by resolution adopted on November 13, 2020, approved the issuance of the Bonds, subject to compliance with the conditions set forth in such resolution, and the Borrowers have complied with such conditions to the satisfaction of the Commission; and

WHEREAS, there have been presented at this meeting drafts or copies, as applicable, of the following documents relating to the issuance of the Bonds:

(a) Trust Agreement, to be dated as of February 1, 2021 (the "2021A Trust Agreement"), between the Commission and The Bank of New York Mellon Trust

Company, N.A., as trustee (in such capacity, the "Bond Trustee"), together with the form of the Series 2021A Bonds attached thereto;

(b) Trust Agreement, to be dated as of February 1, 2021 (the "2021B Trust Agreement" and, together with the 2021A Trust Agreement, the "Trust Agreements"), between the Commission and the Bond Trustee, together with the form of the Series 2021B Bonds attached thereto;

(c) Loan Agreement, to be dated as of February 1, 2021 (the "2021A Loan Agreement"), between the Commission and the Borrowers;

(d) Loan Agreement, to be dated as of February 1, 2021 (the "2021B Loan Agreement" and, together with the 2021A Loan Agreement, the "Loan Agreements"), between the Commission and the Borrowers;

(e) Contract of Purchase, to be dated the date of delivery thereof (the "Contract of Purchase"), between the North Carolina Local Government Commission (the "LGC") and BofA Securities, Inc. and Truist Securities, Inc. (collectively, the "Underwriters"), and approved by the Commission and the Borrowers;

(f) Supplemental Indenture for Obligation No. 18, to be dated as of February 1, 2021 (Supplemental Indenture No. 18"), among the Borrowers and CaroMont Ambulatory Services, LLC ("CAS" and, together with the Borrowers, the "Members of the Obligated Group") and The Bank of New York Mellon Trust Company, N.A., as master trustee (in such capacity, the "Master Trustee"), supplementing the Master Trust Indenture, dated as of October 15, 1995 (as amended and supplemented, the "Master Indenture"), among the Borrowers and The Bank of New York (succeeded by the Master Trustee);

(g) Obligation No. 18, to be dated the date of delivery thereof ("Obligation No. 18"), from the Members of the Obligated Group to the Medical Care Commission, relating to the Series 2021A Bonds;

(h) Supplemental Indenture for Obligation No. 19, to be dated as of February 1, 2021 ("Supplemental Indenture No. 19"), among the Members of the Obligated Group and the Master Trustee, supplementing the Master Indenture;

(i) Obligation No. 19, to be dated the date of delivery thereof ("Obligation No. 19" and, together with Obligation No. 18, the "Obligations"), from the Members of the Obligated Group to the Medical Care Commission, relating to the Series 2021B Bonds;

(j) Supplemental Indenture, to be dated as of February 1, 2021 (the "MTI Amendment Supplemental Indenture" and, together with the Supplemental Indenture No. 18 and the Supplemental Indenture No. 19, the "Supplemental Indentures"), among the Members of the Obligated Group and the Master Trustee, amending certain provisions of the Master Indenture;

(k) Master Indenture; and

(l) Preliminary Official Statement of the Commission, dated January 8, 2021 (the "Preliminary Official Statement"), relating to the offering and sale of the Bonds; and

WHEREAS, the Commission has determined that the Members of the Obligated Group are financially responsible and capable of fulfilling their respective obligations, as applicable, under each of the documents described above to which the Members of the Obligated Group are a party; and

WHEREAS, the Commission has determined that the public interest will be served by the proposed financing and that adequate provision has been made for the payment of the principal of, redemption premium, if any, and interest on the Bonds;

NOW THEREFORE, BE IT RESOLVED by the Executive Committee of the North Carolina Medical Care Commission as follows:

Section 1. Capitalized terms used in this Series Resolution and not defined herein shall have the meanings given such terms in the Trust Agreements, the Loan Agreements and the Master Indenture.

Section 2. 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 $105,260,000. The Bonds shall be dated as of the date of delivery thereof.

The Series 2021A Bonds shall initially bear interest in the Fixed Mode, and the Series 2021B Bonds shall initially bear interest in the Long-Term Mode. The Series 2021A Bonds shall mature, subject to prior redemption, in such amounts and at such times and shall bear interest at such rates as are set forth in Exhibit A attached hereto and made a part hereof. The Series 2021B Bonds shall mature, subject to prior redemption, on February 1, 2051, and shall initially bear interest at a rate of 5.00% per annum during the Initial Long-Term Interest Rate Period. The Series 2021B Bonds will be subject to mandatory tender for purchase on February 1, 2026. The mandatory sinking fund redemption schedule for the Series 2021B Bonds is set forth in Exhibit A hereto.

The Bonds shall be initially issued as fully registered bonds in denominations of $5,000 or any whole multiple thereof. The Bonds shall be initially issued in book-entry only form as described in the Trust Agreements. While the Bonds bear interest at the Fixed Rate and the Long-Term Rate, interest on the Bonds shall be payable semiannually on each February 1 and August 1, beginning August 1, 2021, until the applicable series of Bonds is fully paid or until converted (if ever) to a different Interest Rate Mode. Payments of principal of and interest on the Bonds shall be forwarded by the Bond Trustee to the registered owners of the Bonds in such manner as is set forth in the Trust Agreements.

Section 3. The Series 2021A Bonds shall be subject to optional and extraordinary redemption and optional and mandatory tender at the times, upon the terms and conditions and at the prices set forth in the 2021A Trust Agreement. The Series 2021B Bonds shall be subject to optional, extraordinary and mandatory sinking fund redemption and optional and mandatory tender at the times, upon the terms and conditions and at the prices set forth in the 2021B Trust Agreement.

Section 4. The proceeds of the Series 2021A Bonds shall be applied as provided in Section 2.19 of the 2021A Trust Agreement. The proceeds of the Series 2021B Bonds shall be applied as provided in Section 2.19 of the 2021B Trust Agreement.

Section 5. The forms, terms and provisions of the Loan Agreements and the Trust 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 for such purpose and the Secretary or any Assistant Secretary of the Commission are hereby authorized and directed to execute and deliver the Loan Agreements and the Trust Agreements in substantially the forms presented at this meeting, together with such changes, modifications and deletions as they, with the advice of counsel, may deem necessary or 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 Contract of Purchase; 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 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 for such purpose is hereby authorized and directed to execute and deliver the Contract of Purchase in substantially the form presented at this meeting, together with such changes, modifications, insertions and deletions as such Chairman, the Vice Chairman or such member of the Commission, with the advice of counsel, may deem necessary or appropriate, including but not limited to changes, modifications and deletions necessary to incorporate the final terms of the Bonds; and such execution and delivery shall be conclusive evidence of the approval and authorization thereof by the Commission.

Section 7. The forms of the Bonds set forth in the Trust 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 for such purpose 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 forms presented at this meeting, together with such changes, modifications and deletions as they, with the advice of counsel, may deem necessary or 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, terms and provisions of the Supplemental Indentures and the Obligations are hereby approved in substantially the forms presented at this meeting, together with such changes, modifications and deletions as the Chairman or Vice Chairman, with the advice of counsel, may deem necessary and appropriate; and the execution and delivery of the Trust Agreements by the Commission shall be conclusive evidence of the approval of the Supplemental Indentures and the Obligations by the Commission.

Section 9. The Commission hereby approves and consents to the amendments to the Master Indenture set forth in the MTI Amendment Supplemental Indenture.

Section 10. The Commission hereby approves the action of the LGC in awarding the Bonds to the Underwriters at the price of $128,767,595.20 (which price represents the aggregate

principal amount of the Bonds, plus an original issue premium of $23,832,857.00 and less an underwriters' discount of $325,261.80).

Section 11. Upon execution of the Bonds in the form and manner set forth in the Trust Agreements, the Bonds shall be deposited with the Bond Trustee for authentication, and the Bond Trustee is hereby authorized and directed to authenticate the Bonds and, upon compliance with the provisions of Section 2.19 of the 2021A Trust Agreement and Section 2.19 of the 2021B Trust Agreement, the Bond Trustee shall deliver the Bonds to the Underwriters against payment therefor.

Section 12. The Commission hereby ratifies the use and distribution of the Preliminary Official Statement in connection with the offering and sale of the Bonds. The preparation and distribution of a final Official Statement (the "Official Statement"), in substantially the form of the Preliminary Official Statement, with such changes as are necessary to reflect the final terms of the Bonds, is hereby approved, and the Chairman, the Vice Chairman or any member of the Commission designated in writing by the Chairman for such purpose is hereby authorized to execute and deliver, on behalf of the Commission, the Official Statement in substantially such form, 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 or appropriate; and such execution and delivery 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 Loan Agreements, the Trust Agreements, the Supplemental Indentures, the Obligations and the Master Indenture by the Underwriters in connection with the offering and sale of the Bonds.

Section 13. The Bank of New York Mellon Trust Company, N.A. is hereby appointed as the Bond Trustee for the Bonds.

Section 14. The Depository Trust Company ("DTC") is hereby appointed as the initial Securities Depository for the Bonds, with Cede & Co., as nominee of DTC, being the initial Securities Depository Nominee and initial registered owner of the Bonds. The Commission has heretofore executed and delivered to DTC a Blanket Letter of Representations.

Section 15. S. Mark Payne, Secretary of the Commission, Geary W. Knapp, Assistant Secretary, Kathy C. Larrison, Auditor, Crystal M. Watson-Abbott, Auditor, and Anthony J. Harms, Acting Chief of the Construction Section of the Division of Health Service Regulation, for the Commission, are each hereby appointed a Commission Representative with full power to carry out the duties set forth therein and the Trust Agreements.

Section 16. The Chairman, the Vice Chairman, any member of the Commission designated in writing by the Chairman, the 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 Loan Agreements, the Trust Agreements, the Contract of Purchase and the Official Statement.

Section 17. The Commission hereby recommends that the Governor of the State of North Carolina approve the issuance of the Bonds pursuant to Section 147(f) of the Internal Revenue Code of 1986, as amended, and hereby requests such approval.

Section 18. A comparison of the professional fees as set forth in the resolution of the Commission granting preliminary approval of the Bonds with the actual professional fees incurred in connection with the Bonds is set forth as Exhibit B hereto.

Section 19. This Series Resolution shall take effect immediately upon its adoption.

3. Adjournment

There being no further business, the meeting was adjourned at 11:25 a.m.

Respectfully submitted,

Geary W. Knapp
Assistant Secretary

Date: January 21, 2021

EXHIBIT A

MATURITY SCHEDULE

Series 2021A Bonds

Due February 1	Principal Amount	Interest Rate
2022	$ 345,000	5.00%
2023	360,000	5.00
2024	380,000	5.00
2025	435,000	5.00
2026	480,000	5.00
2027	1,425,000	5.00
2028	1,485,000	5.00
2029	1,790,000	5.00
2030	2,370,000	5.00
2031	2,575,000	5.00
2032	2,805,000	5.00
2033	3,070,000	3.00
2034	3,285,000	3.00
2035	3,505,000	3.00
2036	16,640,000	4.00

Series 2021B Bonds

Due:	February 1, 2051
Initial Long-Term Rate:	5.00%
Last Day of Initial Long-Term Interest Rate Period	January 31, 2026
Long-Term Rate Hard Mandatory Purchase Date:	February 1, 2026

Mandatory Sinking Fund Schedule

Due February 1	Principal Amount
2037	$3,520,000
2038	3,620,000
2039	3,715,000
2040	3,820,000
2041	3,925,000
2042	4,035,000
2043	4,145,000
2044	4,260,000
2045	4,375,000
2046	4,495,000
2047	4,620,000
2048	4,745,000
2049	4,875,000
2050	5,010,000
2051*	5,150,000

* Maturity

EXHIBIT B

PROFESSIONAL FEES

Professional	Preliminary Approval	Actual
Financial Advisor	$ 90,000	$ 90,000
Underwriters' Discount	390,000	325,262
Accountant/Auditor	70,000	60,000
Bond Counsel	120,000	120,000
Underwriters' Counsel	115,000	100,000
Borrowers' Counsel	75,000	80,000
Trustee (including counsel)	12,100	12,100

NC MCC Bond Sale Approval Form
Facility Name: CaroMont Health, Inc.

	Time of Preliminary Approval	Time of Mailing POS (if applicable)	Time of Final Approval	Total Variance	Explanantion of Variance
SERIES: 2021A					
PAR Amount	$51,000,000.00	$39,745,000.00	$40,950,000.00	($10,050,000.00)	Lower interest rates provided higher premiums for the bonds, thereby lowering the par amount of the issue
Estimated Interest Rate [1]	2.57%	1.98%	1.85%	-0.72%	Interest rates decreased and 3% coupons were added helping reduce the "True Interest Cost"
All-in True Interest Cost	2.65%	2.06%	1.91%	-0.74%	Same as above
Maturity Schedule (Interest) - Date	8/1/2021 - 2/1/2040	8/1/2021 - 2/1/2037	8/1/2021 - 2/1/2036	4 years shorter from prelim approval	As interest rates declined, CaroMont was able to shorten the maturity of the serial bonds
Maturity Schedule (Principal) - Date	2/1/2022 - 2/1/2040	2/1/2027 - 2/1/2037	2/1/2022 - 2/1/2036	4 years shorter from prelim approval	Amortization of the serial bonds changed slightly with moves in the market to keep debt service level As interest rates declined, CaroMont was able to shorten the maturity of the serial bonds
Bank Holding Period (if applicable) - Date	N/A [2]	N/A [2]	N/A [2]	-	-
Estimated NPV Savings ($) (if refunded bonds)	N/A [2]	N/A [2]	N/A [2]	-	-
Estimated NPV Savings (%) (if refunded bonds)	N/A [2]	N/A [2]	N/A [2]	-	-

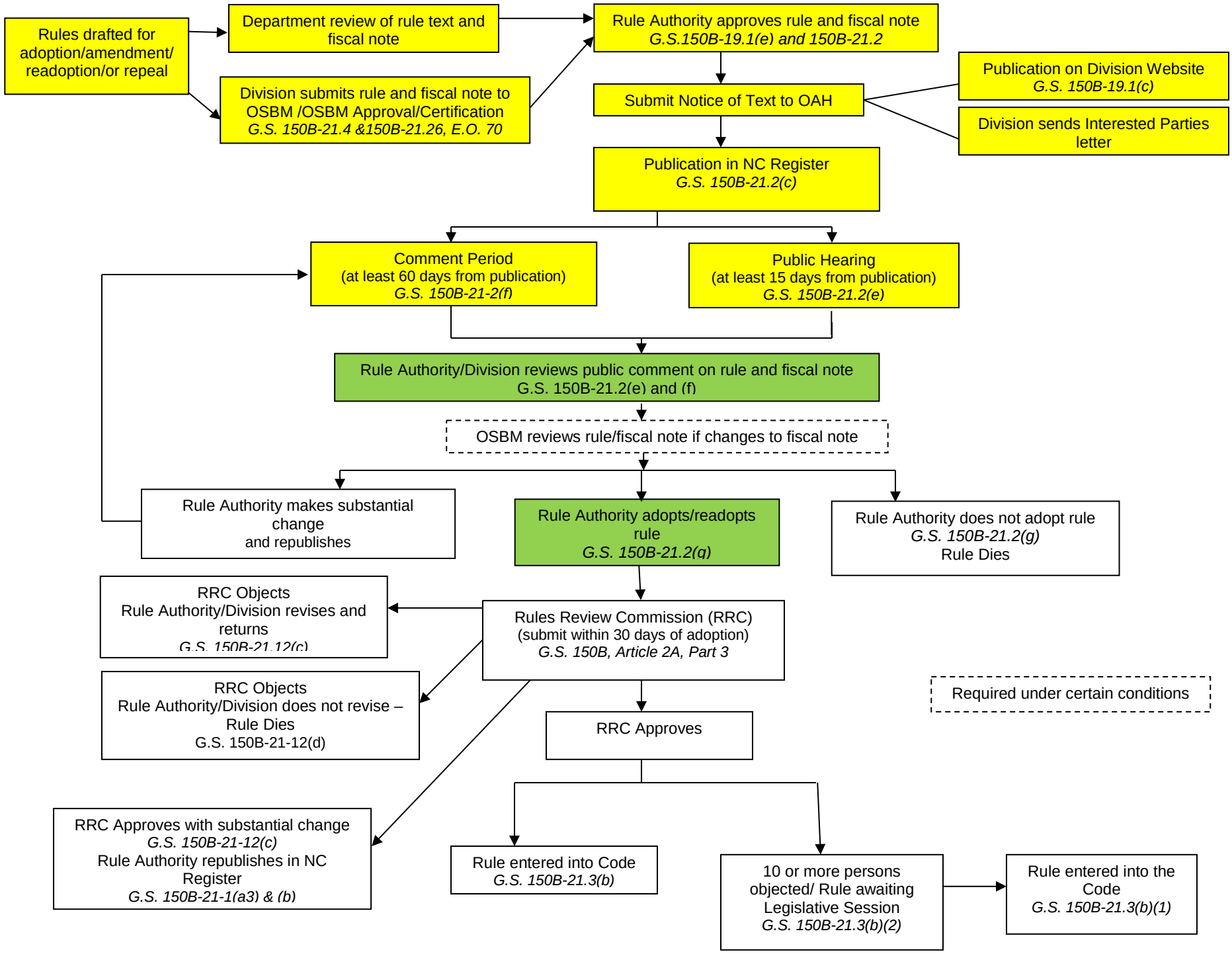
NOTES:
(1) True Interest Cost is shown for Estimated Interest Rate.
(2) The Series 2021 bonds are publicly-offered, fixed-rate, new money bonds.

	Time of Preliminary Approval	Time of Mailing POS (if applicable)	Time of Final Approval	Total Variance	Explanantion of Variance
SERIES: 2021A "Put Bonds"					
PAR Amount	$79,000,000.00	$65,720,000.00	$64,310,000.00	($14,690,000.00)	Lower interest rates provided higher premiums for the bonds, thereby lowering the par amount of the issue
Estimated Interest Rate [1]	1.19%	0.54%	0.46%	-0.73%	Interest rates decreased and call feature was removed, eliminating a yield to maturity increase and reducing the "True Interest Cost"
All-in True Interest Cost	1.26%	0.96%	0.46%	-0.80%	Same as above
Maturity Schedule (Interest) - Date [2]	8/1/2021 - 2/1/2026	8/1/2021 - 2/1/2026	8/1/2021 - 2/1/2026	Unchange	Unchanged
Maturity Schedule (Principal) - Date [3]	2/1/2041 - 2/1/2051	2/1/2036 - 2/1/2041	2/1/2037 - 2/1/2051	Amortization begins 3 years sooner than preliminary approval	Amortization of the "put" bonds changed slightly with moves in the market to keep debt service level; as the 2021A serials maturity was shortened, the 2021 "put" bonds maturity begins sooner CaroMont decided to increase the amortzation back to 30 years, compared to 20 years in the POS, with the thought that they have the ability to shorten the debt later if they'd like
Bank Holding Period (if applicable) - Date	N/A [4]	N/A [4]	N/A [4]	-	-
Estimated NPV Savings ($) (if refunded bonds)	N/A [4]	N/A [4]	N/A [4]	-	-
Estimated NPV Savings (%) (if refunded bonds)	N/A [4]	N/A [4]	N/A [4]	-	-

NOTES:
(1) True Interest Cost is shown for Estimated Interest Rate.
(2) The bonds have a mandatory tender in 5 years, but a 30-year amortization schedule.
(3) The "put" bonds are being wrapped around the 2021A long-term fixed rate series.
(4) The Series 2021 bonds are publicly-offered, fixed-rate, new money bonds.

Process for Medical Care Commission to Adopt/Readopt Rule

Exhibit C



10A NCAC 13O .0301 is amended as published in 35:06 NCR 652-653 as follows:

SECTION .0300 - NURSE AIDE I REGISTRY

10A NCAC 13O .0301 NURSE AIDE I TRAINING AND COMPETENCY EVALUATION

(a) To be eligible to be listed on the NC Nurse Aide I Registry by the Health Care Personnel Education and Credentialing Section, a person ~~shall~~ shall:

(1) pass a Nurse Aide I training program approved by the Department in accordance with 42 CFR ~~Part~~ 483.151 through ~~Part~~ 42 CFR 483.152 and the State of North Carolina's Nurse Aide I competency ~~exam.~~ exam; or

(2) apply to the Department for approval to be listed on the NC Nurse Aide I Registry by reciprocity of a nurse aide certification or registration from another State to North Carolina.

(b) In applying for reciprocity of a nurse aide certification or registration to be listed on the NC Nurse Aide I Registry pursuant to Subparagraph (a)(2) of this Rule, the applicant shall:

(1) submit a completed application to the Department that includes the following:

(A) first, middle, and last name;

(B) the applicant's prior name(s), if any;

(C) mother's maiden name;

(D) gender;

(E) social security number;

(F) date of birth;

(G) mailing address;

(H) email address;

(I) home telephone number;

(J) any other State registries of nurse aides upon which the applicant is listed;

(K) certification or registration numbers for any State nurse aide registries identified in Part (b)(1)(J) of this Rule;

(L) original issue dates for any certifications or registrations identified in Part (b)(1)(K) of this Rule;

(M) expiration dates for any certifications or registrations identified in Part (b)(1)(K) of this Rule; and

(N) employment history;

(2) provide documentation verifying that his or her registry listing is active and in good standing in the State(s) of reciprocity, dated no older than 30 calendar days prior to the date the application is received by the Department; and

(3) provide a copy of his or her Social Security card and an unexpired government-issued identification containing a photograph and signature.

(c) For the applicant to be approved for reciprocity of a nurse aide certification or registration and be listed on the NC Nurse Aide I Registry, the Department shall verify the following:

(1) the applicant has completed an application in accordance with Subparagraph (b)(1) of this Rule;

(2) the applicant is listed on another State's registry of nurse aides as active and in good standing;

(3) the applicant has no pending or substantiated findings of abuse, neglect, exploitation, or misappropriation of resident or patient property recorded on other State registries of nurse aides;

(4) if the applicant has been employed as a nurse aide for monetary compensation consisting of at least a total of eight hours of time worked performing nursing or nursing-related tasks delegated and supervised by a Registered Nurse, then the applicant shall provide the employer name, employer address, and dates of employment for the previous 24 consecutive months;

(5) the name listed on the Social Security card and government-issued identification containing a photograph and signature submitted with the application matches the name listed on another State's registry of nurse aides or that the applicant has submitted additional documentation verifying any name changes; and

(6) the applicant completed a State-approved nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152 or a State-approved competency evaluation program that meets the requirements of 42 CFR 483.154.

(d) The Department shall within 10 business days of receipt of an application for reciprocity of a nurse aide certification or registration or receipt of additional information from the applicant:

(1) inform the applicant by letter whether he or she has been approved; or

(2) request additional information from the applicant.

The applicant shall be added to the NC Nurse Aide I Registry within three business days of Department approval.

~~(b)~~ (e) This Rule incorporates 42 CFR Part 483 Subpart D by reference, including all subsequent amendments and editions. Copies of the Code of Federal Regulations may be accessed electronically free of charge from www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR.

~~(c)~~ (f) The State of North Carolina's Nurse Aide I competency exam shall include each course requirement specified in the Department-approved Nurse Aide I training program as provided for in 42 CFR ~~Part~~ 483.152.

~~(d)~~ (g) The State of North Carolina's Nurse Aide I competency exam shall be administered and evaluated only by the Department or its contracted testing agent as provided for in 42 CFR ~~Part~~ 483.154.

~~(e)~~ (h) The Department shall include a record of completion of the State of North Carolina's Nurse Aide I competency exam in the NC Nurse Aide I Registry within 30 ~~business~~ days of passing the written or oral exam and the skills demonstration as provided for in 42 CFR ~~Part~~ 483.154.

~~(f)~~ (i) If the State of North Carolina's Nurse Aide I competency exam candidate does not pass the written or oral exam and the skills demonstration as provided for in 42 CFR ~~Part~~ 483.154, the candidate shall be advised by the Department of the areas that the individual did not pass.

~~(g)~~ (j) Every North Carolina's Nurse Aide I competency exam candidate shall ~~have, as provided for in 42 CFR Part 483.154,~~ have the opportunity to take the exam at maximum three times before being required to retake and pass a Nurse Aide I training program.

~~(h) A person who is currently listed on any state's Nurse Aide I Registry shall not be required to take the Department-approved Nurse Aide I training program to be listed or, if his or her 24-month listing period has expired, relisted on the NC Nurse Aide I Registry, unless the person fails to pass the State of North Carolina's Nurse Aide I competency exam after three attempts.~~

~~(i)~~ (k) U.S. military personnel who have completed medical corpsman training and retired or non-practicing nurses shall not be required to take the Department-approved Nurse Aide I training program to be listed or relisted on the Nurse Aide I Registry, unless the person fails to pass the State of North Carolina's Nurse Aide I competency exam after three attempts.

History Note: *Authority G.S. 131E-255; 42 CFR ~~Part 483;~~ 483.150; 42 CFR 483.151; 42 CFR 483 .152; 42 CFR 483.154; 42 CFR 483.156; 42 CFR 483.158;*
Eff. January 1, 2016;
Emergency Amendment Eff. April 20, 2020;
Temporary Amendment Eff. June 26, ~~2020.~~ 2020;
Amended Eff. April 1, 2021.

Impact Analysis: Healthcare Personnel Registry Nurse Aide Reciprocity Permanent Rule Amendment

Agency:	N.C. Medical Care Commission
Rule Citation(s):	10A NCAC 13O .0301 (*See proposed rule in Appendix)
Agency Contact:	Jana Busick, Chief, HCPEC jana.busick@dhhs.nc.gov 919-855-3757 Nadine Pfeiffer, Rule Review Manager Nadine.pfeiffer@dhhs.nc.gov 919-855-3811
Rulemaking Authority:	G.S. 131E-255
Impact Summary:	State Government: Yes Local Government: No Private Entities: Yes Substantial Impact: No

Introduction

In April 2020, the North Carolina Medical Care Commission, in accordance with General Statute 150B-21.1A(b), adopted an emergency rule amendment and simultaneously proposed a temporary rule amendment for 10A NCAC 13O .0301 Nurse Aide I Training and Competency Evaluation due to the serious and unforeseen threat to the public health and safety by the COVID-19 virus. The emergency amendment, that became effective April 26, 2020, allowed reciprocity for out-of-state nurse aides who are active and in good standing on another State's nurse aide registry, waiving the state's competency examination. The temporary rule amendment that continued allowing reciprocity became effective June 26, 2020.

This rule proposes to make permanent the amendments to the rule allowing reciprocity for out-of-state nurse aides who are active and in good standing on another State's nurse aide registry. Thus, reciprocity will directly benefit the citizens of North Carolina during the COVID-19 crisis and in the future as the population continues to grow and as more citizens are over the age of 65 and receive care in Skilled Nursing Facilities (SNFs) and Nursing Facilities (NFs).

Background and Purpose

Nurse aides augment the care nurses provide by performing routine duties of caring for patients or residents under the direction of a Registered Nurse or Licensed Practical Nurse. Federal law requires states to confirm and register nurse aides who provide care in nursing homes. This confirmation and registration is obtained through a state-approved nurse aide training program and a state-approved competency examination.

North Carolina's population is growing and aging. In 2019, North Carolina had an estimated population of approximately 10.5 million people. In addition, approximately 16.5.% of individuals were aged 65 or

over. By 2038, North Carolina is projected to have a population of 12.9 million people. Between years 2019 and 2038, the population aged 65 and over is projected to grow at a rate of more than 2.5 times faster than the total population. By 2038, projections indicate that 21% of the population will be aged 65 and over.[1]

Every two years, in conjunction with the Bureau of Labor Statistics (BLS), the North Carolina Department of Commerce publishes a 10-year industry and occupation employment projections for statewide and sub-state areas. It is predicted that by 2026, the Healthcare Support Occupations group will be one of the fastest growing occupational groups in North Carolina with an annualized growth rate of 1.9%. The Healthcare Support Occupations group includes healthcare aides, assistants, etc. Table 1 depicts the employment estimate in 2017 and 2026 for the Health Care Support Occupations group.[2]

Table 1

Occupational Group	Employment Estimate 2017	Employment Estimate 2026	Net Change	Percent Change	Annualized Growth Rate	2017 Annual Median Wage
Healthcare Support Occupations	154,974	183,303	29,329	18.9%	1.9%	$25,420

Mercer, a global health care staffing consultancy, conducted a labor market analysis and projected that the US will likely face a shortage of 95,000 nursing assistants in 2020.[3] Table 2 depicts the North Carolina Department of Commerce's projected average annual openings for the Healthcare Support Occupations group from years 2017 to 2026.[2]

Table 2

Average Annual Openings	Number of Positions
Due to Occupational Separations	18,883
Due to Growth	3,259

On March 10, 2020, the Governor of North Carolina, by issuing Executive Order No.116, declared a state of emergency to coordinate a response and enact protective measures to help prevent the spread of COVID-19. The COVID-19 is a respiratory disease that can result in serious illness or death. The World Health Organization, the Center for Disease Control and Prevention and the United States Department of Health and Human Services declared COVID-19 a public health emergency. In conjunction with government guidance, on March 16, 2020, the state-approved nurse aide I competency exam vendor, NCS Pearson, Inc. d/b/a Pearson VUE, suspended all nurse aide competency examinations in North Carolina until conditions were deemed safe to re-open.

In response to the COVID-19 crisis, the Center for Medicaid and Medicare Services (CMS) waived 42 CFR §483.35(d), except for 42 CFR §483.35(d)(1)(i)), so that they do not present barriers for skilled nursing facilities (SNFs) or nursing facilities (NFs) to provide adequate levels of staffing for the duration of the COVID-19 pandemic. Included in the waiver was 42 CFR §483.35(d)(1)(ii)(A) which references the requirement that a facility must not use an individual working in the facility as a nurse aide for more

[1] OSBM population estimates and projections: https://www.osbm.nc.gov/demog/county-projections
[2] NC Department of Commerce – Labor & Economic Analysis Division:
https://files.nc.gov/nccommerce/documents/LEAD/Projections/2026_NC_Employment_Projections_Summary.pdf
[3] CNN Business: https://money.cnn.com/2018/05/04/news/economy/health-care-workers-shortage/index.html

than 4 months, on a full-time basis, unless the individual has completed a training and competency evaluation program approved the by the State.

Prior to COVID-19, states and health care providers were reporting a shortage of nurse aides. In a report to Congress, CMS determined that 2.4 nurse aide staffing hours per resident per day provided the most impact on short-stay quality outcomes related to hospital transfers for potentially avoidable causes (e.g., urinary tract infections, sepsis, electrolyte imbalance). In addition, CMS determined that 2.8 nurse aide staffing hours per resident per day provided the most impact on long-stay quality outcomes (e.g., functional improvement, incidence of pressure sores, incidence of skin trauma, resisting care improvement and weight loss).[4] Overall, an overwhelming majority of North Carolina's skilled nursing facilities do not meet the recommended nurse aide staffing hours per resident per day threshold (Table 3 and Table 4).[5] The average nurse aide staffing hours per resident per day in North Carolina is 2.17.[5]

Table 3

State	The Percentage of Skilled Nursing Facilities Below the 2.4 Nurse Aide Staffing Hours Per Resident Per Day Threshold	N Value
US	62%	9,213
NC	78%	319
GA	87%	305
SC	66%	117
TN	87%	270
VA	82%	230

Table 4

State	The Percentage of Skilled Nursing Facilities Below the 2.8 Nurse Aide Staffing Hours Per Resident Per Day Threshold	N Value
US	84%	9,213
NC	90%	319
GA	96%	305
SC	83%	117
TN	96%	270
VA	90%	230

Description of Proposed Rule

By implementing reciprocity, North Carolina will recognize the validity of other State nurse aide registries. An out-of-state nurse aide, provided they meet the criteria listed below, will no longer be required to complete the North Carolina nurse aide I competency examination in order to be listed on the North Carolina Nurse Aide I Registry. The current competency examination includes both a written (or oral) examination and a skills evaluation. An individual must pass both components of the examination to be listed on the North Carolina Nurse Aide I Registry.

[4] Congressional Report: https://www.justice.gov/sites/default/files/elderjustice/legacy/2015/07/12/Appropriateness_of_Minimum_Nurse_Staffing_Ratios_in_Nursing_Homes.pdf

[5] Centers for Medicare and Medicaid Services: Nursing Home Compare data analyzed on May 1, 2020

The following reciprocity criteria must be met for an out-of-state nurse aide to be listed on the North Carolina Nurse Aide I Registry.

- The applicant must submit a complete reciprocity application.
- The applicant must be listed on another State's registry of nurse aides as active and in good standing.
- The applicant has no pending or substantiated findings of abuse, neglect, exploitation, or misappropriation of resident or patient property recorded on other State registries of nurse aides.
- if the applicant has been employed as a nurse aide for monetary compensation consisting of at least a total of eight hours of time worked performing nursing or nursing-related tasks delegated and supervised by a Registered Nurse, then the applicant shall provide the employer name, employer address, and dates of employment for the previous 24 consecutive months.
- The name listed on an applicant's Social Security card and unexpired government-issued identification containing a photograph and signature submitted with the application must match the name listed on another State's registry of nurse aides or that the applicant has submitted additional documentation verifying any name changes.
- The applicant completed a State-approved nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152 or a State-approved competency evaluation program that meets the requirements of 42 CFR 483.154.

Impact Analysis

By allowing reciprocity, the agency expects to reduce costs and turnaround times for out-of-state nurse aides seeking work in North Carolina. In addition, reciprocity could increase the number of out-of-state applicants seeking approval to work in North Carolina compared to the past three years, but the extent of this effect is uncertain. Compared to current rules, reciprocity may help to address nurse aide staffing needs but waiving the competency exam also increases the potential risk to residents and patients.

Out-of-State Nurse Aides

Under current rules, out-of-state nurse aides must pass the North Carolina nurse aide I competency examination. The fee to complete both the written (or oral) examination and skills evaluation is $120. An individual continues to pay an examination fee each time they do not pass a component of the exam. An out-of-state nurse aide has three opportunities to complete and pass the examination before they are required to retake nurse aide training. Table 5 depicts the fees associated with the North Carolina nurse aide I competency examination.[6]

Table 5*

Examination Type	Fee
Written Examination and Skills Evaluation	$120
Oral (English or Spanish) Examination & Skills Evaluation	$120
Written Examination Only (re-test)	$30
Oral (English or Spanish) Examination Only (re-test)	$30
Skills Evaluation Only (re-test)	$90

* The first time an individual takes the competency examination, they must complete both the written (or oral) examination and the skills evaluation.

[6] Fees are associated with NCS Pearson, Inc. d/b/a Pearson VUE. Pearson VUE is the state-approved nurse aide I competency evaluation program vendor

Reciprocity waives the competency examination requirement to be listed on the North Carolina Nurse Aide I Registry and therefore the associated fees that must be incurred by an out-of-state nurse aide. Table 6 indicates that in each of the last three years, at minimum, approximately 700 out-of-state nurse aides were approved by the agency to take the North Carolina nurse aide I competency examination in order to be listed on the NC Nurse Aide I Registry. If the trend continues, the total savings to out-of-state nurse aides is a minimum of $84,000.

Table 6*

Calendar Year	The Total Number of Training Waivers Approved by the Agency	The Number of Training Waivers Approved from Out-of-State Nurse Aides to Take the Competency Examination in North Carolina	The Percentage of Total Training Waivers Approved from Out-of-State Nurse Aides
2017	1520	900	59%
2018	1365	800	59%
2019	1300	700	54%

*Approximations

Reciprocity expedites the timeframe by at least 12 days for an out-of-state nurse aide to be listed on the NC Nurse Aide I Registry and thus supports healthcare facilities in the ability to fill nurse aide vacancies sooner. Prior to reciprocity, out-of-state nurse aides were required to apply for a training waiver in order to not have to complete the state-approved nurse aide training in North Carolina. On average, each training waiver application is reviewed by the agency within two or three business days. Once the waiver application is approved, then the agency notifies the state-approved competency examination vendor so that the out-of-state nurse aide can register and select a date to take the competency examination. Out-of-state nurse aides can register within approximately two days of agency approval but must wait an additional 12 days to take the exam so that the state-approved competency examination vendor can ensure adequate examination personnel and testing materials are at each test site. In some instances, an out-of-state nurse aide may have to wait beyond the 12 days depending on the availability of test dates.

Healthcare Facilities and Clients

According to a report published in 2002 by the Office of Inspector General, nurse aides care for between 10-15 nursing home residents per shift and find it difficult to deliver quality care to all residents entrusted to them, especially when positions remain unfilled.[7] Therefore, reciprocity does address the nurse aide staffing shortage in North Carolina. However, reciprocity may increase the risk to clients and place an additional burden on healthcare facilities for on-the-job training since approximately 66% of out-of-state nurse aides do not pass the nurse aide I competency examination the first time. Assuming applicant trends continue, over 450 out of state nurse aide applicants fail their competency exam annually; these applicants would be added to North Carolina's Registry under reciprocity.[8]

Tables 7 indicates that approximately 33% of out-of-state nurse aides successfully passed the North Carolina nurse aide I competency examination the first time. Table 8 depicts the number of out-of-state nurse aides that took the competency examination more than once and passed.[8]

[7] Office of Inspector General: https://oig.hhs.gov/oei/reports/oei-05-01-00030.pdf

[8] Data provided by NCS Pearson, Inc. d/b/a Pearson VUE. Pearson VUE is the state-approved nurse aide I competency evaluation program vendor.

Table 7*

Fiscal Year	Written (Or Oral) Examination Passed	Skills Evaluation Examination Passed	Passed Both Examinations
July 1, 2016 to June 30, 2017	483	137	135
July 1, 2017 to June 30, 2018	430	137	134
July 1, 2018 to June 30, 2019	399	159	156

*First time test takers only

Table 8*

Fiscal Year	Written (Or Oral) Examination Passed	Skills Evaluation Examination Passed
July 1, 2016 to June 30, 2017	19	75
July 1, 2017 to June 30, 2018	12	72
July 1, 2018 to June 30, 2019	11	76

*Repeat test takers only

To ensure the safety of those receiving care by nurse aides, the North Carolina Board of Nursing has determined the nursing tasks which can be performed by nurse aides in North Carolina. In addition, the North Carolina Board of Nursing requires that a registered nurse validate the competencies of each nurse aide prior to delegating nursing tasks. Ultimately, a licensed nurse maintains accountability and responsibility for the delivery of safe and competence care. The licensed nurse must monitor the client's status and response to care provided on an ongoing basis.[9]

Decisions regarding the delegation of tasks to nurse aides are made by the licensed nurse on a case-by-case basis. All the following criteria must be met before delegation of any task can occur:[9]

- The task is performed frequently in the daily care of a client or group of clients
- The task is performed according to an established sequence of steps.
- The task involves little to no modification from one client situation to another.
- The task may be performed with a predictable outcome.
- The task does not involve on-going assessment, interpretation or decision-making that cannot be separated from the task itself.
- The task does not endanger the client's life or well-being.

<u>Division of Health Service Regulation (DHSR)</u>

From April 20, 2020 to June 20, 2020, DHSR received 788 reciprocity applications.

- 368 applications were approved
- 27 applications were denied
- 374 applications were deemed incomplete
- 19 applications had a pending status

DHSR receives approximately 20 reciprocity applications per business day. If this trend continues, DHSR will receive approximately 5,000 reciprocity applications annually.

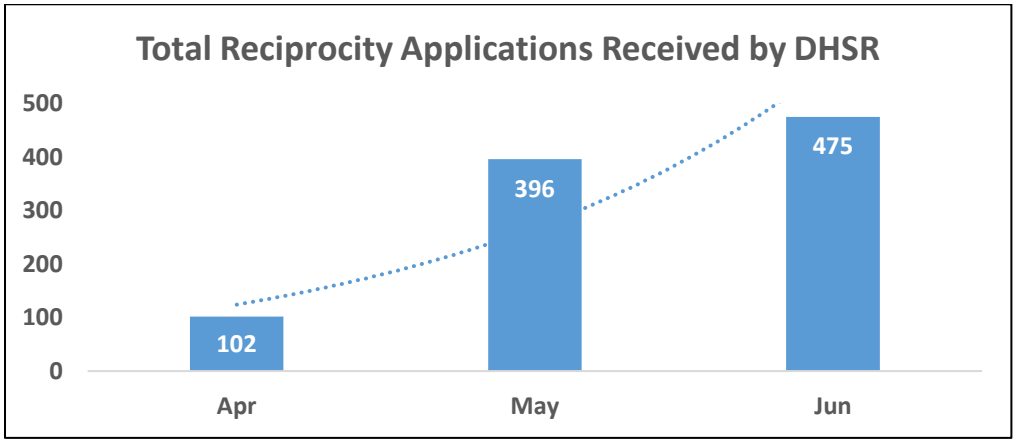
[9] North Carolina Board of Nursing: https://www.ncbon.com/vdownloads/nurse-aide/nurse-aide-i-tasks-2010-revisions.pdf

The amount of time needed by staff to process each reciprocity application is approximately 60 minutes. Staffing costs are approximately $27 per hour including wages and benefits. The total estimated annual cost for DHSR staff to process 5,000 reciprocity applications is $135,000.

The average number of days from when DHSR receives a reciprocity application to when DHSR notifies the applicant of the agency's decision is approximately 4 business days. This timeframe is in alignment with other states.

- Georgia: 14 business days
- Missouri: 7-10 days
- Montana: 5-7 days
- Nebraska: 30 days
- Rhode Island: a minimum of 8 weeks for the entire licensure process to be completed
- Tennessee: 1 week
- Virginia: 30-45 business days

The permanent rule allows DHSR 10 business days to process a reciprocity application. Currently, DHSR's processing rate is 4 business days. According to the graph below, the number of reciprocity applications received from April 20, 2020 to June 28, 2020 has increased each month. The rule currently allows for adequate processing time. However, if the number of applications continues to increase exponentially, DHSR will need additional staff to meet the 10-business day timeframe.



Summary

Overall, North Carolina should implement reciprocity not only during the COVID-19 pandemic but seek to make reciprocity a permanent rule in year 2021. As the population in North Carolina continues to increase, specifically regarding individuals aged 65 and older, North Carolina will likely experience an annual nurse aide staffing shortage due to either occupational separations or occupational growth.[10] As vacancies regarding nurse aide positions in nursing homes increase, it becomes even more challenging for existing nurse aides to deliver quality of care to all residents entrusted to them.[11]

Reciprocity aims to reduce the nurse aide shortage in North Carolina. By implementing reciprocity, the requirement for all out-of-state nurse aides, in active and good standing status, to take the nurse aide I competency examination in order to be listed on the NC Nurse Aide I Registry is no longer required. In addition, reciprocity eliminates the financial burden for out-of-state nurse aides to pay at least $120 to

[10] NC Department of Commerce – Labor & Economic Analysis Division: https://files.nc.gov/nccommerce/documents/LEAD/Projections/2026_NC_Employment_Projections_Summary.pdf
[11] Office of Inspector General: https://oig.hhs.gov/oei/reports/oei-05-01-00030.pdf

take the nurse aide I competency examination. Furthermore, reciprocity expedites the timeframe by at least 12 days for an out-of-state nurse aide to be listed on the NC Nurse Aide I Registry and thus supports healthcare facilities in the ability to fill nurse aide vacancies sooner.

However, reciprocity may increase the risk to clients and place an additional burden on healthcare facilities for on-the-job training. Assuming applicant trends continue, approximately 66% of out-of-state nurse aide applicants fail the competency examination annually; these applicants would be added to the North Carolina Nurse Aide I Registry under reciprocity.[12]

The overall estimated projected annual cost to DHSR to implement reciprocity is $135,000. Since the implementation of reciprocity in April 2020, as an emergency rule and temporary rule, DHSR has received approximately 20 reciprocity applications per business day. Of the applications received, approximately 50% are approved. Thus, if this trend continues, reciprocity has the potential to add more than 2,000 nurse aides annually to help alleviate the nurse aide shortage in North Carolina.

[12] Data provided by NCS Pearson, Inc. d/b/a Pearson VUE. Pearson VUE is the state-approved nurse aide I competency evaluation program vendor.

Appendix: Proposed Rule Text

10A NCAC 13O .0301 is proposed for amendment as follows:

SECTION .0300 - NURSE AIDE I REGISTRY

10A NCAC 13O .0301 NURSE AIDE I TRAINING AND COMPETENCY EVALUATION

(a) To be eligible to be listed on the NC Nurse Aide I Registry by the Health Care Personnel Education and Credentialing Section, a person ~~shall~~ shall:

(1) pass a Nurse Aide I training program approved by the Department in accordance with 42 CFR ~~Part~~ 483.151 through ~~Part~~ 42 CFR 483.152 and the State of North Carolina's Nurse Aide I competency ~~exam.~~ exam; or

(2) apply to the Department for approval to be listed on the NC Nurse Aide I Registry by reciprocity of a nurse aide certification or registration from another State to North Carolina.

(b) In applying for reciprocity of a nurse aide certification or registration to be listed on the NC Nurse Aide I Registry pursuant to Subparagraph (a)(2) of this Rule, the applicant shall:

(1) submit a completed application to the Department that includes the following:

(A) first, middle, and last name;

(B) the applicant's prior name(s), if any;

(C) mother's maiden name;

(D) gender;

(E) social security number;

(F) date of birth;

(G) mailing address;

(H) email address;

(I) home telephone number;

(J) any other State registries of nurse aides upon which the applicant is listed;

(K) certification or registration numbers for any State nurse aide registries identified in Part (b)(1)(J) of this Rule;

(L) original issue dates for any certifications or registrations identified in Part (b)(1)(K) of this Rule;

(M) expiration dates for any certifications or registrations identified in Part (b)(1)(K) of this Rule; and

(N) employment history;

(2) provide documentation verifying that his or her registry listing is active and in good standing in the State(s) of reciprocity, dated no older than 30 calendar days prior to the date the application is received by the Department; and

(3) provide a copy of his or her Social Security card and an unexpired government-issued identification containing a photograph and signature.

(c) For the applicant to be approved for reciprocity of a nurse aide certification or registration and be listed on the NC Nurse Aide I Registry, the Department shall verify the following:

(1) the applicant has completed an application in accordance with Subparagraph (b)(1) of this Rule;

(2) the applicant is listed on another State's registry of nurse aides as active and in good standing;

(3) the applicant has no pending or substantiated findings of abuse, neglect, exploitation, or misappropriation of resident or patient property recorded on other State registries of nurse aides;

(4) if the applicant has been employed as a nurse aide for monetary compensation consisting of at least a total of eight hours of time worked performing nursing or nursing-related tasks delegated and supervised by a Registered Nurse, then the applicant shall provide the employer name, employer address, and dates of employment for the previous 24 consecutive months;

(5) the name listed on the Social Security card and government-issued identification containing a photograph and signature submitted with the application matches the name listed on another State's registry of nurse aides or that the applicant has submitted additional documentation verifying any name changes; and

(6) the applicant completed a State-approved nurse aide training and competency evaluation program that meets the requirements of 42 CFR 483.152 or a State-approved competency evaluation program that meets the requirements of 42 CFR 483.154.

(d) The Department shall within 10 business days of receipt of an application for reciprocity of a nurse aide certification or registration or receipt of additional information from the applicant:

(1) inform the applicant by letter whether he or she has been approved; or

(2) request additional information from the applicant.

The applicant shall be added to the NC Nurse Aide I Registry within three business days of Department approval.

~~(b)~~ (e) This Rule incorporates 42 CFR Part 483 Subpart D by reference, including all subsequent amendments and editions. Copies of the Code of Federal Regulations may be accessed electronically free of charge from www.gpo.gov/fdsys/browse/collectionCfr.action?collectionCode=CFR.

~~(c)~~ (f) The State of North Carolina's Nurse Aide I competency exam shall include each course requirement specified in the Department-approved Nurse Aide I training program as provided for in 42 CFR ~~Part~~ 483.152.

~~(d)~~ (g) The State of North Carolina's Nurse Aide I competency exam shall be administered and evaluated only by the Department or its contracted testing agent as provided for in 42 CFR ~~Part~~ 483.154.

~~(e)~~ (h) The Department shall include a record of completion of the State of North Carolina's Nurse Aide I competency exam in the NC Nurse Aide I Registry within 30 ~~business~~ days of passing the written or oral exam and the skills demonstration as provided for in 42 CFR ~~Part~~ 483.154.

~~(f)~~ (i) If the State of North Carolina's Nurse Aide I competency exam candidate does not pass the written or oral exam and the skills demonstration as provided for in 42 CFR ~~Part~~ 483.154, the candidate shall be advised by the Department of the areas that the individual did not pass.

~~(g)~~ (j) Every North Carolina's Nurse Aide I competency exam candidate shall ~~have, as provided for in 42 CFR Part 483.154,~~ have the opportunity to take the exam at maximum three times before being required to retake and pass a Nurse Aide I training program.

~~(h) A person who is currently listed on any state's Nurse Aide I Registry shall not be required to take the Department-approved Nurse Aide I training program to be listed or, if his or her 24-month listing period has expired, relisted on~~

~~the NC Nurse Aide I Registry, unless the person fails to pass the State of North Carolina's Nurse Aide I competency exam after three attempts.~~

~~(i)~~ (k) U.S. military personnel who have completed medical corpsman training and retired or non-practicing nurses shall not be required to take the Department-approved Nurse Aide I training program to be listed or relisted on the Nurse Aide I Registry, unless the person fails to pass the State of North Carolina's Nurse Aide I competency exam after three attempts.

History Note: *Authority G.S. 131E-255; 42 CFR ~~Part 483;~~ 483.150; 42 CFR 483.151; 42 CFR 483 .152; 42 CFR 483.154; 42 CFR 483.156; 42 CFR 483.158;*
Eff. January 1, 2016;
Emergency Amendment Eff. April 20, 2020;
Temporary Amendment Eff. June 26, ~~2020.~~ 2020;
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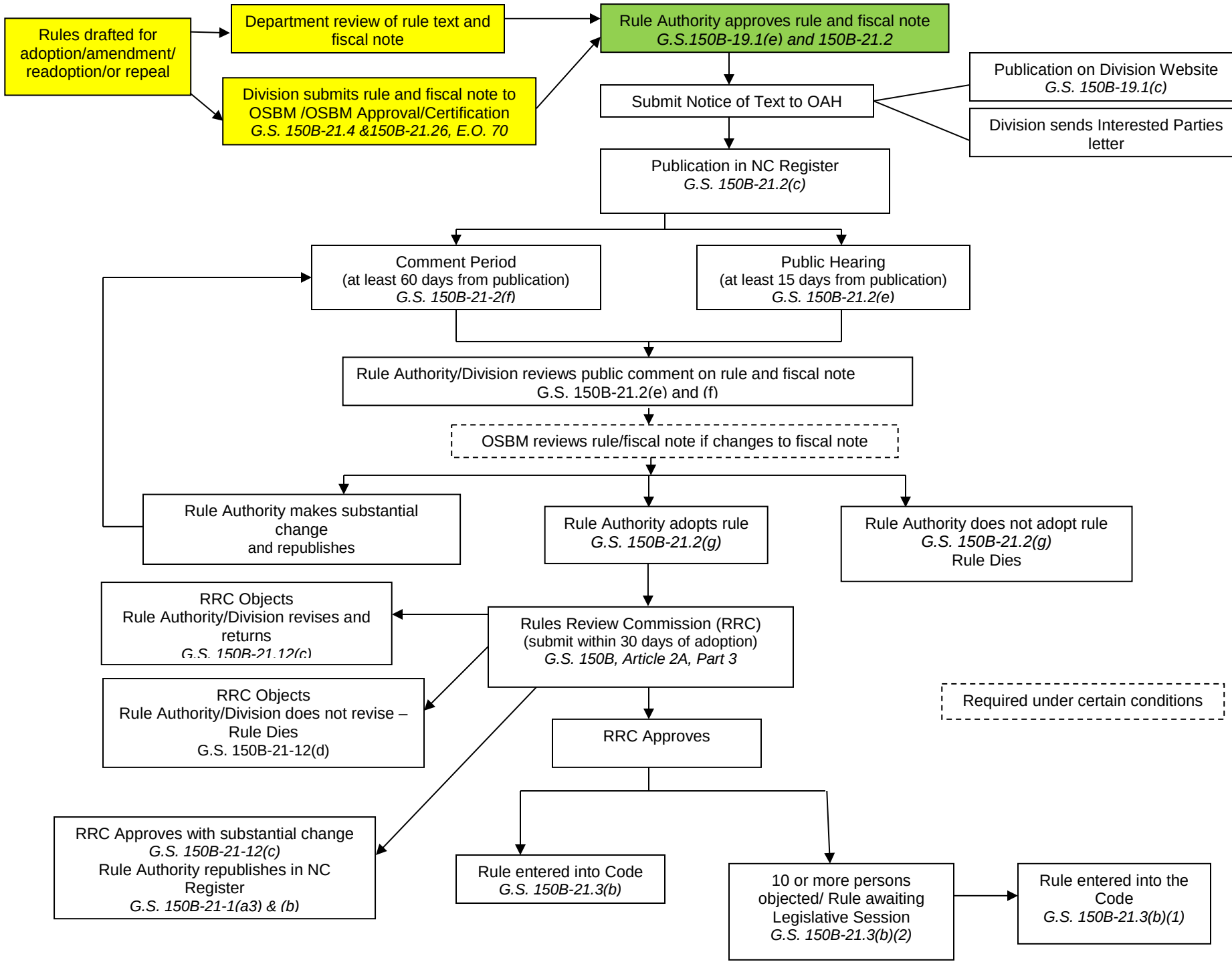
Process for Medical Care Commission to Initiate Rulemaking

Exhibit D



10A NCAC 13K .1109 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1109 RESIDENT CARE AREAS

(a) ~~Resident rooms shall meet the following requirements:~~ A facility shall meet the following requirements for resident bedrooms:

(1) ~~There shall be private or semiprivate rooms;~~ private bedroom with not less than 100 square feet of floor area or semi-private bedroom with not less than 80 square feet of floor area per bed shall be provided;

(2) ~~Infants~~ infants and small children shall not ~~be assigned to~~ share a ~~room~~ bedroom with an adult resident unless requested by ~~residents~~ the resident and families;

(3) ~~Each resident room~~ each bedroom shall ~~contain at least~~ be furnished with a bed, a mattress protected by waterproof material, a mattress pad, a pillow, and ~~a chair;~~ one chair per resident;

(4) ~~Each resident room shall have a minimum of 48 cubic feet of closet space or wardrobe for clothing and personal belongings that provides security and privacy for each resident. Each resident room shall be equipped with a towel rack for each individual;~~ each bedroom shall be provided with one closet or wardrobe per bed. Each closet or wardrobe shall have clothing storage space of not less than 48 cubic feet per bed with one-half of this space for hanging clothes;

(5) ~~Each resident~~ each bedroom shall:

(A) be located at or above grade level;

(B) ~~have provisions to ensure visual privacy for treatment or visiting;~~ be provided with a cubicle curtain enclosing each bed to ensure visual privacy; and

(C) be equipped with a towel rack for each resident;

(6) ~~Artificial lighting shall be provided sufficient~~ each bedroom shall provide lighting for treatment and non-treatment needs, 50 ~~foot candles~~ foot-candles for ~~treatment,~~ treatment needs, and 35 ~~foot candles~~ foot-candles for non-treatment ~~areas;~~ needs; and

(7) ~~A room where access is through a bathroom, kitchen or another bedroom will not be approved for a resident's bedroom.~~ no resident bedroom shall be accessed through a bathroom, kitchen, or another bedroom.

(b) ~~Bathrooms shall meet the following requirements:~~ A facility shall meet the following requirements for bathrooms:

(1) ~~Bathroom facilities~~ bathrooms shall be ~~conveniently~~ directly accessible to ~~resident rooms.~~ each resident bedroom without going through the general corridors. One bathroom may serve up to four ~~residents and staff.~~ residents. ~~Minimum size of any bathroom shall be 18 square feet.~~ The ~~door~~ bathroom doorway shall ~~be at least 32 inches wide.~~ be a minimum 32-inch clear opening;

(2) ~~The~~ each bathroom shall be furnished with the following:

(A) a toilet with grab bars;

(B) ~~lavatory with four inch wrist blade controls;~~ a sink trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall

not be less than four inches in length. If the sink faucet depends on the building electrical service for operation, the faucet must have an emergency power source or battery backup capability. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets;

(C) a mirror;

(D) soap, paper towel dispensers, and waste paper receptacle with a removable impervious liner; and

~~(E) water closet; and~~

~~(F)~~(E) a tub or shower.

(c) ~~Space shall be provided for:~~ Each facility shall provide:

(1) ~~charting, storage of supplies and personal effects of staff;~~ an area for charting;

(2) ~~the storage of resident care equipment;~~ storage provisions for personal effects of staff;

(3) ~~housekeeping equipment and cleaning supplies;~~ storage areas for supplies and resident care equipment;

(4) ~~storage of test reagents and disinfectants distinct from medication;~~ storage area(s) for housekeeping equipment and cleaning supplies;

(5) ~~locked medication storage and preparation; and~~ a medication preparation area with a counter, a sink trimmed with valves that can be operated without hands, locked medication storage, and a double locked narcotic storage area under visual control of staff. If the sink is equipped with blade handles, the blade handles shall not be less than four inches in length. If the sink faucet depends on the building electrical service for operation, the faucet must have an emergency power source or battery backup capability. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets;

(6) ~~drugs requiring refrigeration. They may be stored in a separate locked box in the refrigerator or in a lockable drug only refrigerator, capable of maintaining a temperature range of 36 degrees F (2 degrees C) to 46 degrees F (8 degrees C). The storage and accountability of controlled substances shall be in accordance with the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes.~~ a lockable refrigerator for drug storage only or a separate locked box in a facility refrigerator. The refrigerator must be capable of maintaining a temperature range of 36 degrees F (2 degrees C) to 46 degrees F (8 degrees C);

(7) a kitchen with:

(A) a refrigerator;

(B) a cooking appliance ventilated to the outside;

(C) a 42- inch minimum double-compartment sink and domestic dishwashing machine capable of sanitizing dishes with 160 degrees F water; and

(D) storage space for non-perishables;

(8) a separate dining area measuring not less than 20 square feet per resident bed;

(9) a recreational and social activities area with not less than 150 square feet of floor area exclusive of corridor traffic;

(10) a nurses'calling system shall be provided:

(A) in each resident bedroom for each resident bed. The call system activator shall be such that they can be activated with a single action and remain on until deactivated by staff at the point of origin. The call system activator shall be within reach of a resident lying on the bed. In rooms containing two or more call system activators, indicating lights shall be provided at each calling station;

(B) nurses' calling systems which provide two-way voice communication shall be equipped with an indicating light at each calling station which lights and remains lighted as long as the voice circuit is operating;

(C) a nurses' call emergency activator shall be proved at each residents' use toilet fixture, bath, and shower. The call system activator shall be accessible to a resident lying on the floor; and

(D) calls shall register with the floor staff and shall activate a visible signal in the corridor at the resident's door. In multi-corridor units, additional visible signals shall be installed at corridor intersections;

(11) heating and air conditioning equipment that can maintain a temperature range between 68 degrees and 80 degrees Fahrenheit, even upon loss of utility power.

~~(d) Kitchen and dining areas shall have:~~

~~(1) a refrigerator;~~

~~(2) a cooking unit ventilated to the outside;~~

~~(3) a 42 inch minimum double compartment sink and domestic dishwashing machine capable of sanitizing dishes with 160 degrees F. water;~~

~~(4) dining space of 20 square feet per resident; and~~

~~(5) storage space for non-perishables.~~

~~(e) Other areas shall include:~~

~~(1) a minimum of 150 square feet exclusive of corridor traffic for recreational and social activities;~~

~~(2) an audible and accessible call system furnished in each resident's room and bathroom; and~~

~~(3) heating and air cooling equipment to maintain a comfort range between 68 degrees and 80 degrees Fahrenheit.~~

History Note: *Authority G.S. 131E-202;*
Eff. June 1, 1991;
Amended Eff. February 1, ~~1995.~~ 1995;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1112 is proposed for amendment as follows:

10A NCAC 13K .1112 DESIGN AND CONSTRUCTION

(a) ~~Hospice residences and inpatient units~~ A new facility or remodeling of an existing facility ~~must~~ shall meet the requirements of the North Carolina State Building ~~Code~~ Codes, which are incorporated by reference, including all subsequent amendments and editions, in effect at the time of licensure, construction, additions, alterations or repairs. Copies of these codes may be purchased from the International Code Council online at https://shop.iccsafe.org/ at a cost of eight hundred fifty-eight dollars ($858.00) or accessed electronically free of charge at https://codes.iccsafe.org/codes/north-carolina. Existing licensed facilities shall meet the requirements of the North Carolina State Building Codes in effect at the time of licensure, construction or remodeling.

(b) Each facility shall be planned, constructed, and equipped to support the services to be offered in the facility.

(c) Any existing building converted to a hospice facility shall meet all requirements of a new facility.

(d) The sanitation, water supply, sewage disposal, and dietary facilities ~~must comply with the rules of the Commission for Public Health.~~ shall meet the requirements of Rule 15A NCAC 18A .1300, which is incorporated by reference including subsequent amendments and editions.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, ~~2018.~~ 2018;
Amended Eff. October 1, 2021.

10A NCAC 13K .1113 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1113 PLANS AND SPECIFICATIONS

(a) When construction or remodeling of a facility is planned, ~~final working drawings and specifications must~~ one copy of construction documents and specifications shall be submitted by the owner or the owner's appointed representative to the Department ~~of Health and Human Services, Division of Health Service Regulation~~ for review and approval. ~~Schematic~~ Schematic design drawings and ~~preliminary working~~ design development drawings ~~shall~~ may be submitted ~~by the owner prior to the required submission of final working drawings.~~ for approval prior to the required submission of construction documents. ~~The Department shall forward copies of each submittal to the Department of Insurance and Division of Environmental Health for review and approval. Three copies of the plans shall be provided at each submittal.~~

(b) ~~Construction work shall not be commenced until written approval has been given by the Department.~~ Approval of ~~final plans~~ construction documents and specifications shall be obtained from the Department prior to licensure. Approval of construction documents and specifications shall expire one year ~~from the date granted unless a contract for the construction has been signed prior to the expiration date.~~ after the date of approval unless a building permit for the construction has been obtained prior to the expiration date of the approval of construction documents and specifications.

(c) If an approval expires, ~~a~~ renewed approval shall be issued by the Department, provided revised ~~plans~~ construction documents and specifications meeting ~~all current regulations, codes, and~~ the standards established in Sections .1100 and .1200 of this Subchapter are ~~submitted.~~ submitted by the owner or owner's appointed representative and reviewed by the Department.

(d) ~~Completed construction shall conform to the minimum standards established in these Rules.~~ Any changes made during construction shall require the approval of the Department to ensure compliance with the standards established in Sections .1100 and .1200 of this Subchapter.

(e) ~~The owner or designated agent shall notify the Department when actual construction starts and at points when construction is 75 percent and 90 percent complete and upon final completion, so that periodic and final inspections can be performed.~~ Completed construction or remodeling shall conform to the standards established in Sections .1100 and .1200 of this Subchapter. Construction documents and building construction, including the operation of all building systems, shall be approved in writing by the Department prior to licensure or patient and resident occupancy.

(f) The owner or owner's ~~designated agent~~ appointed representative shall ~~submit for approval by the Department all alterations or remodeling changes which affect the structural integrity of the building, functional operation, fire safety or which add beds or facilities over those for which the facility is licensed.~~ notify the Department in writing either by U.S. Mail or e-mail when the construction or remodeling is complete.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, 1991;
Amended Eff. February 1, ~~1996.~~ 1996;

Readopted Eff. October 1, 2021.

10A NCAC 13K .1114 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1114 PLUMBING

~~(a) The water supply shall be designed, constructed and protected so as to assure that a safe, potable and adequate water supply is available for domestic purposes in compliance with the North Carolina State Building Code.~~

~~(b) All plumbing in the residence or unit shall be installed and maintained in accordance with the North Carolina State Plumbing Code. All plumbing shall be maintained in good repair and free of the possibility of backflow and backsiphonage, through the use of vacuum breakers and fixed air gaps, in accordance with state and local codes.~~

~~(c)~~ For ~~homes~~ hospice residential facilities with five or more residents, a 50-gallon quick recovery water heater is required. For ~~homes~~ hospice residential facilities with fewer than five residents, a 40-gallon quick recovery water heater is required.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, ~~1991.~~ 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1115 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1115 WASTE DISPOSAL

(a) Sewage shall be discharged into a public sewer system, or ~~if such is not available, it~~ in the absence of a public sewer system, sewage shall be disposed of in a manner approved by the North Carolina ~~Division of Environmental Health.~~ Department of Health and Human Services, Division of Public Health, Environmental Health Section.

(b) Garbage and rubbish shall be stored in impervious containers in ~~such~~ a manner as ~~not to become a nuisance or a health hazard.~~ to prevent insect breeding and public health nuisances. ~~A sufficient number of impervious~~ Impervious containers with tight-fitting lids shall be provided and kept clean and in good repair. ~~Refuse~~ Garbage shall be removed from the outside storage at least once a week to a disposal site approved by the local health ~~department.~~ department having jurisdiction.

(c) The ~~home~~ facility or unit shall ~~be maintained free of infestations of insects and rodents, and all openings to the outside shall be screened.~~ take measures to keep insects, rodents, and other vermin out of the residential care facility. All openings to the outer air shall be protected against the entrance of flying insects by screens, closed doors, closed windows, or other means.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, ~~1991.~~ 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1116 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1116 APPLICATION OF PHYSICAL PLANT REQUIREMENTS

The physical ~~plan~~ plant requirements for each hospice residential facility or unit shall be applied as follows:

(1) New construction shall comply with all the requirements of ~~Section .1100 of this Subchapter;~~ this Section;

(2) ~~Existing~~ Except where otherwise specified, existing buildings shall meet the licensure and code requirements in effect at the time of licensure, construction, ~~alteration~~ alteration, or ~~modification;~~ modification.

~~(3) New additions, alterations, modifications, and repairs shall meet the technical requirements of Section .1100 of this Subchapter; however, where strict conformance with current requirements would be impracticable, the authority having jurisdiction may approve alternative measures where the facility can demonstrate to the Department's satisfaction that the alternative measures do not reduce the safety or operating effectiveness of the facility;~~

~~(4)~~(3) Rules contained in ~~Rule .1109 of~~ this Section are minimum requirements and are not intended to prohibit buildings, ~~systems~~ systems, or operational conditions that exceed minimum ~~requirements;~~ requirements.

~~(5)~~(4) ~~Equivalency: Alternate methods, procedures, design criteria, and functional variations from the physical plant requirements, because of extraordinary circumstances, new programs, or unusual conditions, may be approved by the authority having jurisdiction when the facility can effectively demonstrate to the Department's satisfaction that the intent of the physical plant requirements are met and that the variation does not reduce the safety or operational effectiveness of the facility; and~~ The Division may grant an equivalency to allow alternate methods, procedures, design criteria or functional variation from the requirements of this Rule and the rules contained in this Section. The equivalency may be granted by the Division when a governing body submits a written equivalency request to the Division that states the following:

(a) the rule citation and the rule requirement that will not be met due to strict conformance with current requirements would be impractical, extraordinary circumstances, new programs, or unusual conditions;

(b) the justification for the equivalency; and

(c) how the proposed equivalency meets the intent of the corresponding rule requirement.

(5) In determining whether to grant an equivalency request the Division shall consider whether the request will reduce the safety and operational effectiveness of the facility. The governing body shall maintain a copy of the approved equivalence issued by the Division.

(6) Where ~~rules or codes~~ rules, codes, or standards have any conflict, the more stringent requirement shall apply.

History Note: *Authority G.S. 131E-202;*
Eff. February 1, ~~1996.~~ 1996;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1201 is proposed for readoption with substantive changes as follows:

SECTION .1200 - HOSPICE INPATIENT CARE

10A NCAC 13K .1201 REQUIREMENTS FOR HOSPICE INPATIENT UNITS

(a) Hospice inpatient facilities or units ~~must~~ shall conform to the rules outlined in ~~10A NCAC 13K~~ Sections .0100 through .1100 of this Subchapter and ~~those in this Section.~~ the rules of this Section.

(b) Hospice inpatient units located in a licensed hospital shall meet the requirements of 10A NCAC ~~13B with the exception of:~~ 13B, which is incorporated by reference with subsequent amendments and editions except for rules: 10A NCAC 13B .1912, .1919, .1922, and .1923.

(c) Hospice inpatient units located in a licensed nursing facility shall meet the requirements of 10A NCAC ~~13D with the exception of: 10A NCAC 13D .0507, .0600, .0800, .0907, .1004, .1200 and .1300.~~ 13D, which is incorporated by reference with subsequent amendments and editions.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, ~~1991.~~ 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1204 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1204 ADDITIONAL PATIENT CARE AREA REQUIREMENTS FOR HOSPICE INPATIENT UNITS

(a) ~~The floor area of a single bedroom shall not be less than 100 square feet and the floor area of a room for more than one bed shall not be less than 80 square feet per bed. The 80 square feet and 100 square feet requirements shall be exclusive of closets, toilet rooms, vestibules or wardrobes.~~ A facility shall meet the following requirements for patient bedrooms:

(1) private bedrooms shall be provided with not less than 100 square feet of floor area;

(2) semi-private bedrooms with not less than 80 square feet of floor area per bed; and

(3) floor space for closets, toilet rooms, vestibules, or wardrobes shall not be included in the floor areas required by this Paragraph.

(b) ~~The total space set aside for dining, recreation and other common uses shall not be less than 30 square feet per bed. Physical therapy and occupational therapy space shall not be included in this total.~~ A facility shall meet the following requirements for dining, recreation, and common use areas:

(1) floor space for dining, recreation, and common use shall not be less than 30 square feet per bed;

(2) the dining, recreation, and common use areas required by this Paragraph may be combined; and

(3) floor space for physical and occupational therapy shall not be included in the areas required by this Paragraph.

(c) ~~A toilet room shall be directly accessible from each patient room and from each central bathing area without going through the general corridor. One toilet room may serve two patient rooms but not more than eight beds. The lavatory may be omitted from the toilet room if one is provided for each 15 beds not individually served. There shall be a wheelchair and stretcher accessible central bathing area for staff to bathe a patient who cannot perform this activity independently. There shall be at least one such area per each level in a multi-level facility.~~ A facility shall meet the following requirements for toilet rooms, tubs, showers, and central bathing areas:

(1) a toilet room shall contain a toilet fixture and a sink trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four inches in length. If the sink faucet depends on the building electrical service for operation, the faucet shall be connected to the essential electrical system. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets;

(2) if a sink is provided in each bedroom, the toilet room is not required to have a sink;

(3) a toilet room shall be accessible from each bedroom without going through the general corridors;

(4) one toilet room may serve two bedrooms, but not more than four beds; and

(5) a minimum of one central bathing area. In multi-level facilities, each patient floor shall contain a minimum of one central bathing area. Central bathing area(s) shall be provided with the following:

(A) wheelchair and stretcher accessible for staff to bathe a patient who cannot perform this activity independently;

(B) a bathtub, a manufactured walk-in bathtub, a similar manufactured bathtub designed for easy transfer of patients and residents into the tub, or a shower designed and equipped for unobstructed ease of stretcher entry and bathing on three sides. Bathtubs shall be accessible on three sides. Manufactured walk-in bathtubs or a similar manufactured bathtub shall be accessible on two sides;

(C) a roll-in shower designed and equipped for unobstructed ease of shower chair entry and use. If a bathroom with a roll-in shower designed and equipped for unobstructed ease of shower chair entry adjoins each bedroom in the facility, the central bathing area is not required to have a roll-in shower;

(D) toilet fixture and lavatory; and

(E) an individual cubicle curtain enclosing each toilet, tub, and shower. A closed cubicle curtain at one of these plumbing fixtures shall not restrict access to the other plumbing fixtures.

(d) For each nursing unit ~~or fraction thereof~~ on each floor, the following shall be provided:

(1) ~~an adequate medication preparation area with counter, sink with four inch handles, medication refrigerator, eye level medication storage, cabinet storage, and double locked narcotic storage room, located adjacent to the nursing station or under visual control of the nursing station;~~ a medication preparation area with:

(A) a counter;

(B) a double locked narcotic storage area under the visual control of nursing staff;

(C) a medication refrigerator;

(D) medication storage visible by staff standing on the floor;

(E) cabinet storage; and

(F) a sink trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four inches in length. If the sink faucet depends on the building electrical service for operation, the faucet shall be connected to the essential electrical system. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets;

(2) ~~a clean utility room with counter, sink with four inch handles, wall and under counter storage;~~ a clean utility room with:

(A) a counter;

(B) storage; and

(C) a sink trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four inches in length. If the sink

faucet depends on the building electrical service for operation, the faucet shall be connected to the essential electrical system. If the sink has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets;

(3) ~~a soiled utility room with counter, sink with four inch handles, wall and under counter storage, a flush rim clinical sink or water closet with a suitable device for cleaning bedpans and a suitable means for washing and sanitizing bedpans and other utensils;~~ a soiled utility room with:

(A) a counter;

(B) storage; and

(C) a sink trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four inches in length. If the sink faucet depends on the building electrical service for operation, the faucet shall be connected to the essential electrical system. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets. The soiled utility room shall be equipped for the cleaning and sanitizing of bedpans as required by Rule 15A NCAC 18A .1312, which is incorporated by reference including subsequent amendments and editions;

(4) a nurses' toilet and locker space for personal belongings;

(5) an audiovisual nurse-patient call system arranged to ensure that a patient's call in the facility ~~is noted at a staffed station;~~ notifies and directs staff to the location where the call was activated;

(6) a soiled linen storage ~~area;~~ room with a hand sanitizing dispenser. If the soiled linen storage room is combined with the soiled utility room, a separate soiled linen storage room is not required;

(7) a clean linen storage room ~~area; and~~ provided in one or more of the following:

(A) a separate linen storage room;

(B) cabinets in the clean utility room; or

(C) a linen closet; and

(8) ~~at least one~~ a janitor's closet.

(e) Dietary and laundry each ~~must~~ shall have a separate janitor's closet.

(f) Stretcher and wheelchair storage shall be provided.

(g) ~~Bulk~~ The facility shall provide storage ~~shall be provided~~ at the rate of not less than five square feet of floor area per licensed bed. This storage space shall:

(1) be used by patients to store personal belongings and suitcases;

(2) be either in the facility or within 500 feet of the facility on the same site; and

(3) be in addition to the other storage space required by this Rule.

(h) Office space shall be provided for ~~persons with administrative responsibilities for the unit.~~ business transactions. Office space shall be provided for persons holding the following positions if these positions are provided:

(1) administrator;

(2) director of nursing;

(3) social services director;

(4) activities director; and

(5) physical therapist.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, 1991;
Amended Eff. February 1, ~~1996.~~ 1996;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1205 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1205 FURNISHINGS FOR HOSPICE INPATIENT CARE

(a) ~~Handgrips shall be provided for~~ A facility shall provide handgrips at all toilet and bath facilities used by patients. Handrails shall be provided on both sides of all corridors where corridors are defined by walls and used by patients.

(b) For each nursing unit ~~or fraction thereof~~ on each floor, the following shall be provided:

(1) a nourishment station ~~with work space, cabinet, and refrigerated storage, a small stove or hotplate in an area physically~~ separated from the nurses' ~~station; and~~ station with:

(A) work space;

(B) cabinets;

(C) refrigerated storage;

(D) a sink trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four inches in length. If the sink faucet depends on the building electrical service for operation, the faucet shall be connected to the essential electrical system. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets;

(E) a small stove, microwave, or hot plate; and

(2) ~~one~~ a nurses' station ~~consisting of adequate desk space for writing, storage space for office supplies and storage space for patients' records.~~ with:

(A) desk space for writing;

(B) storage space for office supplies; and

(C) storage space for patients' records.

(c) ~~Flameproof privacy screens or curtains shall be provided~~ A facility shall provide flame resistant cubicle curtains in multi-bedded rooms.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, ~~1991.~~ 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1206 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1206 HOSPICE INPATIENT FIRE AND SAFETY REQUIREMENTS

~~(a) A new facility shall meet the requirements of the current North Carolina State Building Code and the following additional requirements:~~

~~(1) Where nursing units are located on the same floor with other departments or services, the facility shall be designed to provide separation from the other departments or services with a smoke barrier.~~

~~(2) Horizontal exits are not permitted in any new facility.~~

~~(3) An addition to an existing facility shall meet the same requirements as a new facility except that in no case shall more than one horizontal exit be used to replace a required exit to the outside. For all construction, an emergency generating set, including the prime mover and generator, shall be located on the premises and shall be reserved exclusively for supplying the emergency electrical system.~~

~~(b)~~(a) The hospice shall establish written policies and procedures governing disaster preparedness and fire protection.

~~(c) The hospice shall have an acceptable written plan periodically rehearsed with staff with procedures to be followed in the event of an internal or external disaster, and for the care of casualties of patients and personnel arising from such disasters.~~

(b) The hospice shall have detailed written plans and procedures to meet potential emergencies and disasters, including fire and severe weather.

(c) The plans and procedures shall be made available upon request to local or regional emergency management offices.

(d) The facility shall provide training for all employees in emergency procedures upon employment and annually.

(e) The facility shall conduct unannounced drills using the emergency procedures.

(f) The facility shall ensure that:

(1) the patients' environment remains as free of accident hazards as possible; and

(2) each patient receives adequate supervision and assistance to prevent accidents.

~~(d)~~(g) The fire protection plan shall include:

(1) instruction for all personnel in use of alarms, ~~fire fighting~~ firefighting equipment, methods of fire containment, evacuation ~~routes and~~ routes, procedures for calling the fire ~~department~~ department, and the assignment of specific tasks to all personnel in response to an alarm; and

(2) fire drills for each shift of personnel at least quarterly.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, ~~1991.~~ 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1207 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1207 HOSPICE INPATIENT REQUIREMENTS FOR HEATING/AIR CONDITIONING

~~Heating and cooling systems shall meet the current American Society of Heating, Refrigeration, and Air Conditioning Engineers Guide and National Fire Protection Association Code 90A, which is hereby adopted by reference pursuant to G.S. 150B-14(c), with the following modification:~~ A facility shall provide heating and cooling systems complying with the following:

(1) ~~Soiled linen, bathrooms, janitor closets and soiled utility rooms must have negative pressure with relationship to adjacent areas.~~ The American National Standards Institute and American Society of Heating, Refrigerating, and Air Conditioning Engineers Standard 170: Ventilation of Health Care Facilities, which is incorporated by reference, including all subsequent amendments and editions, and may be purchased for a cost of ninety-four dollars ($94.00) online at https://www.techstreet.com/ashrae/index.html. This incorporation does not apply to Section 9.1, Table 9-1 Design Temperature for Skilled Nursing Facility. The environmental temperature control systems shall be capable of maintaining temperatures in the facility at 71 degrees F. minimum in the heating season and a maximum of 81 degrees F. during non-heating season, even upon loss of utility power; and

(2) ~~Clean linen, clean utility and drug rooms must have positive pressure with relationship to adjacent areas.~~ The National Fire Protection Association 90A: Standard for the Installation of Air-Conditioning and Ventilating Systems, which is incorporated by reference, including all subsequent amendments and editions, and may be purchased at a cost of fifty dollars and fifty cents ($50.50) from the National Fire Protection Association online at http://www.nfpa.org/catalog/ or accessed electronically free of charge at http://www.nfpa.org/aboutthecodes/AboutTheCodes.asp?DocNum=90A.

~~(3) All areas not covered in Paragraphs (1) and (2) of this Rule must have neutral pressure.~~

History Note: *Authority G.S. 131E-202;*
Eff. June 1, ~~1991.~~ 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1208 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1208 HOSPICE INPATIENT ~~REQUIREMENTS/EMERGENCY~~ REQUIREMENTS FOR EMERGENCY ELECTRICAL SERVICE

~~Emergency electrical service shall be provided~~ A facility shall provide an emergency electrical service for use in the event of failure of the normal electrical service. This emergency electrical service shall ~~be made up as follows:~~ consist of the following:

(1) In any existing ~~facility, the following must be provided:~~ facility:

(a) type 1 or 2 emergency lights as required by the North Carolina State Building ~~Code;~~ Codes: Electrical Code;

(b) additional emergency lights for all ~~nursing stations,~~ nurses' stations required by Rule .1205(b)(2) of this Section, ~~drug~~ medication preparation areas required by Rule .1204(d)(1) of this Section, ~~and~~ storage areas, and for the telephone switchboard, if applicable;

(c) one or more portable battery-powered lamps at each ~~nursing station;~~ nurses' station; and

(d) a ~~suitable~~ source of emergency power for life-sustaining ~~equipment~~ equipment, if the facility admits or cares for occupants needing such equipment, to ensure continuous operation with on-site fuel storage for a minimum of 72 hours.

(2) ~~Any addition to an existing facility shall meet the same requirements as new construction.~~ An emergency power generating set, including the prime mover and generator, shall be located on the premises and shall be reserved exclusively for supplying the essential electrical system. For the purposes of this Rule, the "essential electrical system" means a system comprised of alternate sources of power and all connected distribution systems and ancillary equipment, designed to ensure continuity of electrical power to designated areas and functions of a facility during disruption of normal power sources, and also to minimize disruption within the internal wiring system as defined by the North Carolina State Building Codes: Electrical Code.

(3) ~~Any conversion of an existing building such as a hotel, motel, abandoned hospital or abandoned school, shall meet the same requirements for emergency electrical services as required for new construction.~~ Emergency electrical services shall be provided as required by the North Carolina State Building Codes: Electric Code with the following modification: Section 517.10(B)(2) of the North Carolina State Building Codes: Electrical Code shall not apply to new facilities.

(4) ~~Battery-powered corridor lights shall not replace the requirements for the emergency circuit nor be construed to substitute for the generator set. Sufficient fuel shall be stored for the operation of the emergency generator for a period not less than 72 hours, on a 24 hour per day operational basis. The system shall be test run for a period of not less than 15 minutes on a weekly schedule. Records of running time shall be maintained and kept available for reference.~~

~~(5) To ensure proper evaluation of design of emergency power systems, the owner or operator shall submit with final working drawings and specifications a letter describing the policy for admissions~~

~~and discharges to be used when the facility begins operations. If subsequent inspections for licensure indicate the admission policies have been changed, the facility will be required to take immediate steps to meet appropriate code requirements for continued licensure.~~

~~(6) Lighting for emergency electrical services shall be provided in the following places:~~

~~(a) exit ways and all necessary ways of approach exits, including exit signs and exit direction signs, exterior of exits exit doorways, stairways, and corridors;~~

~~(b) dining and recreation rooms;~~

~~(c) nursing station and medication preparation area;~~

~~(d) generator set location, switch gear location, and boiler room, if applicable; and~~

~~(e) elevator, if required for emergency.~~

~~(7) The following emergency equipment which is essential to life, safety, and the protection of important equipment or vital materials shall be provided:~~ The following equipment, devices, and systems that are essential to life safety and the protection of important equipment or vital materials shall be connected to the equipment branch of the essential electrical system as follows:

(a) nurses' calling system;

~~(b) alarm system, including fire alarm actuated at manual stations, water flow alarm devices of sprinkler systems if electrically operated, fire detecting and smoke detecting systems, paging or speaker systems if intended for issuing instructions during emergency conditions, and alarms required for nonflammable medical gas systems, if installed;~~

~~(c)~~(b) fire pump, if installed;

~~(d)~~(c) sewerage or sump lift pump, if installed;

~~(e)~~(d) one elevator, where elevators are used for vertical transportation of patients;

~~(f)~~(e) equipment such as burners and pumps necessary for operation of one or more boilers and their necessary auxiliaries and controls, required for heating and sterilization, if installed; and

~~(g) equipment necessary for maintaining telephone service.~~

(f) task illumination of boiler rooms, if applicable.

(5) The following equipment, devices, and systems that are essential to life safety and the protection of important equipment or vital materials shall be connected to the life safety branch of the essential electrical system as follows:

(a) alarm system, including fire alarm actuated at manual stations, water flow alarm devices of sprinkler systems if electrically operated, fire detecting and smoke detecting systems, paging or speaker systems if intended for issuing instructions during emergency conditions, and alarms required for nonflammable medical gas systems, if installed; and

(b) equipment necessary for maintaining telephone service.

~~(8)~~(6) Where electricity is the only source of power normally used for ~~space heating, the emergency service~~ the heating of space, an essential electrical system shall be provided for heating of patient rooms.

Emergency heating of patient rooms ~~will~~ shall not be required in areas where the facility is supplied by at least two separate generating ~~sources,~~ sources or a network distribution system with the facility feeders so routed, connected, and protected that a fault any place between the ~~generators~~ generating sources and the facility will not likely cause an ~~interruption.~~ interruption of more than one of the facility service feeders.

~~(9)~~(7) ~~The emergency~~ An essential electrical system shall be so controlled that after interruption of the normal electric power supply, the generator is brought to full voltage and frequency and connected within ~~ten~~ 10 seconds through one or more primary automatic transfer switches to all emergency lighting, alarms, ~~nurses' call,~~ and equipment necessary for maintaining telephone ~~service, and receptacles in patient corridors.~~ service. All other lighting and equipment required to be connected to the ~~emergency~~ essential electrical system shall either be connected through the ~~ten~~ 10 second primary automatic transfer switching or shall be ~~subsequently~~ connected through ~~other~~ delayed automatic or manual transfer switching. If manual transfer switching is provided, staff of the facility shall operate the manual transfer switch. ~~Receptacles~~ Electrical outlets connected to the ~~emergency~~ essential electrical system shall be ~~distinctively~~ marked for identification.

(8) Fuel shall be stored for the operation of the emergency power generator for a period not less than 72 hours, on a 24-hour per day operational basis with on-site fuel storage. The generator system shall be tested and maintained per National Fire Protection Association Health Care Facilities Code, NFPA 99, 2012 edition, which is incorporated by reference, including all subsequent amendments and editions. Copies of this code may be purchased at a cost of seventy-nine and fifty cents ($79.50) from the National Fire Protection Association - online at http://www.nfpa.org/catalog/ or accessed electronically free of charge at http://www.nfpa.org/aboutthecodes/AboutTheCodes.asp?DocNum=99. The facility shall maintain records of the generator system tests and shall make these records available to the Division for inspection upon request.

(9) The electrical emergency service at existing facilities shall comply with the requirements established in this Section in effect at the time a license is first issued. Any remodeling of an existing facility that results in changes to the emergency electrical service shall comply with the requirements established in this Section in effect at the time of remodeling.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, ~~1991.~~ 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1209 is proposed for amendment as follows:

10A NCAC 13K .1209 HOSPICE INPATIENT REQUIREMENTS FOR GENERAL ELECTRICAL

(a) All main water supply shut off valves in the sprinkler system must be electronically supervised so that if any valve is closed an alarm will sound at a continuously manned central station.

(b) No two adjacent emergency life safety branch lighting fixtures shall be on the same circuit.

(c) Receptacles in bathrooms must have ground fault protection.

(d) Each patient bed location must be provided with a minimum of ~~four~~ eight single or ~~two~~ four duplex receptacles.

(e) Each patient bed location must be supplied by at least two branch ~~circuits.~~ circuits, one from the equipment branch and one from the normal system.

(f) The fire alarm system must be installed to transmit an alarm automatically to the fire department that is, legally committed to serve the area in which the facility is located, by the direct and reliable method approved by local ordinances.

(g) In patient areas, fire alarms shall be gongs or chimes rather than horns or bells.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, ~~2018.~~ 2018;
Amended Eff. October 1, 2021.

10A NCAC 13K .1210 is proposed for amendment as follows:

10A NCAC 13K .1210 OTHER HOSPICE INPATIENT REQUIREMENTS

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

(1) in each patient bedroom for each patient bed. The call system activator shall be such that they can be activated with a single action and remain on until deactivated by staff at the point of origin. The call system activator shall be within reach of a patient lying on the bed. In rooms containing two or more call system activators, indicating lights shall be provided at each calling station;

(2) nurses' calling systems which provide two-way voice communication shall be equipped with an indicating light at each calling station which lights and remains lighted as long as the voice circuit is operating;

(3) a nurses' call emergency activator shall be proved at each patients' use toilet fixture, bath, and shower. The call system activator shall be accessible to a patient lying on the floor; and

(4) calls shall register with the floor staff and shall activate a visible signal in the corridor at the patient's door. In multi-corridor units, additional visible signals shall be installed at corridor intersections.

(b) At least one telephone shall be available in each area to which patients are admitted and additional telephones or extensions as are necessary to ensure availability in case of need.

(c) General outdoor lighting shall be provided adequate to illuminate walkways and drive.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, ~~2018.~~ 2018;
Amended Eff. October 1, 2021.

10A NCAC 13K .1211 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1211 ADDITIONAL PLUMBING REQUIREMENTS/HOSPICE INPATIENT UNITS

~~For inpatient units, the hot water system shall be adequate to provide:~~

	~~Patient Areas~~	~~Dietary~~	~~Laundry~~
~~Gallons per hour per bed~~	~~6 ½~~	~~4~~	~~4 1/2~~
~~Temperature degrees F.~~	~~110-116~~	~~140 (min)~~	~~140 (min)~~

Hospice inpatient facilities or units shall provide a flow of hot water within safety ranges specified as follows:

(1) Patient Areas – 6 ½ gallons per hour per bed and at a temperature of 100 to 116 degrees F;

(2) Dietary Services – 4 gallons per hour per bed and at a minimum temperature of 140 degrees F; and

(3) Laundry Area – 4 ½ gallons per hour per bed and at a minimum temperature of 140 degrees F.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, ~~1991.~~ 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1212 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1212 APPLICATION OF PHYSICAL PLANT REQUIREMENTS

The physical plant requirements for each hospice inpatient facility or unit shall be applied as follows:

(1) New construction shall comply with all the requirements of ~~Section .1200 of this Subchapter;~~ this Section.

(2) ~~Existing~~ Except where otherwise specified, existing buildings shall meet the licensure and code requirements in effect at the time of licensure, construction, alteration, or ~~modification;~~ modification.

~~(3) New additions, alterations, modifications, and repairs shall meet the technical requirements of Section .1100 of this Subchapter; however, where strict conformance with current requirements would be impracticable, the authority having jurisdiction may approve alternative measures where the facility can demonstrate to the Department's satisfaction that the alternative measures do not reduce the safety or operating effectiveness of the facility;~~

~~(4)~~(3) Rules contained in ~~Rule .1210 of~~ this Section are minimum requirements and are not intended to prohibit buildings, ~~systems~~ systems, or operational conditions that exceed minimum ~~requirements;~~ requirements.

~~(5)~~(4) ~~Equivalency: Alternate methods, procedures, design criteria, and functional variations from the physical plant requirements, because of extraordinary circumstances, new programs, or unusual conditions, may be approved by the authority having jurisdiction when the facility can effectively demonstrate to the Department's satisfaction, that the intent of the physical plant requirements are met and that the variation does not reduce the safety or operational effectiveness of the facility; and~~ The Division may grant an equivalency to allow alternate methods, procedures, design criteria or functional variation from the requirements of this Rule and the rules contained in this Section. The equivalency may be granted by the Division when a governing body submits a written equivalency request to the Division that states the following:

(a) the rule citation and the rule requirement that will not be met due to strict conformance with current requirements would be impractical, extraordinary circumstances, new programs, or unusual conditions;

(b) the justification for the equivalency; and

(c) how the proposed equivalency meets the intent of the corresponding rule requirement.

(5) In determining whether to grant an equivalency request the Division shall consider whether the request will reduce the safety and operational effectiveness of the facility. The governing body shall maintain a copy of the approved equivalence issued by the Division.

(6) Where ~~rules or codes~~ rules, codes, or standards have any conflict, the more stringent requirement shall apply.

History Note: *Authority G.S. 131E-202;*
Eff. February 1, ~~1996.~~ 1996;
Readopted Eff. October 1, 2021.

Fiscal Impact Analysis of
Permanent Rule Readoption without Substantial Economic Impact

Agency Proposing Rule Change
North Carolina Medical Care Commission

Contact Persons
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Impact Summary

Federal Government:	No Impact
State Government:	No Impact
Local Government:	No Impact
Private Sector:	Negligible Impact
Substantial Impact:	No

Titles of Rule Changes and Statutory Citations
(See Appendix for rule text)

10A NCAC 13K

Section .1100 – Hospice Residential Care
- Resident Care Areas 10A NCAC 13K .1109 (Readopt)
- Design and Construction 10A NCAC 13K .1112 (Amended)
- Plans and Specifications 10A NCAC 13K .1113 (Readopt)
- Plumbing 10A NCAC 13K .1114 (Readopt)
- Waste Disposal 10A NCAC 13K .1115 (Readopt)
- Application of Physical Plant Requirements 10A NCAC 13K .1116 (Readopt)

Section .1200 – Hospice Inpatient Care
- Requirements for Hospice Inpatient Units 10A NCAC 13K .1201 (Readopt)
- Additional Patient Care Area Requirements for Hospice Inpatient Units 10A NCAC 13K .1204 (Readopt)
- Furnishings for Hospice Inpatient Care 10A NCAC 13K .1205 (Readopt)
- Hospice Inpatient Fire and Safety Requirements 10A NCAC 13K .1206 (Readopt)
- Hospice Inpatient Requirements for Heating/Air Conditioning 10A NCAC 13K .1207 (Readopt)
- Hospice Inpatient Requirements for Emergency Electrical Service 10A NCAC 13K .1208 (Readopt)

- Hospice Inpatient Requirements for General Electrical 10A NCAC 13K .1209 (Amended)
- Other Hospice Inpatient Requirements 10A NCAC 13K .1210 (Amended)
- Additional Plumbing Requirements/Hospice Inpatient Units 10A NCAC 13K .1211 (Readopt)
- Application of Physical Plant Requirements 10A NCAC 13K .1212 (Readopt)

Authorizing Statutes

G.S. 131E-202

Background

Under authority of G.S. 150B-21.3A, periodic review and expirations of existing rules, the Medical Care Commission, Rule Review Commission, and the Joint Legislative Administrative Procedure Oversight Committee approved the Subchapter report with classifications for the rules located at 10A NCAC 13K – Hospice Licensing Rules – on August 10, 2018, October 18, 2018, and December 22, 2018, respectively. The following thirteen rules were proposed for readoption with substantive changes in this report: 10A NCAC 13K .1109, .1113, .1114, .1115, .1116, .1201, .1204, .1205, .1206, .1207, .1208, .1211, and .1212. The following three rules were amended: 10A NCAC 13K .1112, .1209, and .1210.

There is a total of 208 licensed Hospice Facilities in North Carolina. Of the 208 Hospice Facilities, only 41 facilities have beds in 35 counties. The total bed count includes 452 inpatient hospice beds and 159 residential hospice beds. The inpatient hospice beds are licensed by the State of North Carolina and certified to receive Medicare reimbursement from the Centers for Medicare and Medicaid Services (CMS), therefore meeting both state licensure requirements and CMS federal regulations.

The current physical plant rules in 10A NCAC 13K – Hospice Licensing Rules have not been amended since June of 1991. The rules are antiquated when compared to current trends in the design of hospice facilities. The majority of the proposed amendments to the Hospice Residential and Inpatient Care rules are technical changes intended to provide clarity for staff use, update the rules to reflect current procedures of the Construction Section, remove ambiguity, and provide consistency with other rules.

Rules Summary and Anticipated Fiscal Impact

Rules in Section .1100 – Hospice Residential Care

Most of the rule changes applicable to hospice facilities' residential care beds involve re-organizing and re-formatting the rules, making them easier to use and to provide clarity. Due to duplicity, some rules were removed that are enforced by the North Carolina State Building Codes and the Division of Public Health.

Substantive changes to the facility requirements in these rules include:

- Bedroom minimum square footage,
- Sink and faucet specifications
- Nurses calling systems specifications,
- Facility design and construction approval processes, and
- Plans and Specifications

Rule .1109 – Resident Care Areas

The agency is proposing to readopt this rule with substantive changes. Paragraph (a)(1) is revised to require all hospice residential bedrooms to be a minimum of 100 square feet per floor area for private bedrooms and a minimum of 80 square feet per floor area for semi-private bedrooms. With the probability of future conversion of residential bedrooms to licensed inpatient bedrooms upon Certificate of Need approval for that county, the proposed change to the rule coincides with the minimum requirements set forth under Rule .1204 for inpatient rooms. Adding minimum size requirements to the rule minimizes potential additional costs to convert rooms to minimum sizes in the future. Residential bedrooms are currently designed to meet or exceed the minimum requirements set forth in this rule.

Paragraph (b)(2) and Paragraph (c)(5) were revised to read the same as requirements added for sinks and faucets under Rule .1204. These changes were made to have consistency between the two Subchapters.

Paragraph (c)(10) was revised to provide clarity on the placement and location of nurse call devices to ensure the devices are accessible to all residents and notifies staff. These changes were made to be consistent with the same requirements under Rule .1210.

Rule .1112 – Design and Construction

The agency is proposing to amend this rule. This rule is revised to update the information concerning access to current editions of the North Carolina State Building Codes, and to incorporate by reference the requirements of Rule 15A NCAC 18A – Rules Governing the Sanitation of Hospitals, Nursing Homes, Adult Care Homes, and Other Institutions. The North Carolina State Building Codes were incorporated by reference in the existing Rule .1112. 15A NCAC 18A were not incorporated by reference in the existing Rule .1112. However, existing Rule .1112 (d) required the sanitation, water supply, sewage disposal, and dietary facilities must comply with the rules of the Commission for Public Health.

Rule .1113 – Plans and Specifications

The agency is proposing to readopt this rule with substantive changes. This rule did not impose new requirements. The rule was revised to eliminate the requirement to mandate submittal of schematic and preliminary working drawings prior to final construction drawings being submitted. The remaining changes made to this rule are technical changes and changes to provide clarity.

Fiscal Impact

Despite these new requirements, the agency does not anticipate any impact to hospice facilities due to the changes to the residential rules in Section .1100 because there are no freestanding hospice facilities with just residential hospice beds in North Carolina. All residential hospice beds are included as a separate building wing within a licensed hospice facility with inpatient hospice beds. All residential hospice beds are designed and built to meet the more stringent requirements of inpatient hospice beds so that these beds can convert easily to inpatient beds in the future when permitted by a Certificate of Need for that county. Any costs or benefits to hospice facilities would be due to changes to the inpatient rules which are discussed below.

Rules in Section .1200 – Hospice Inpatient Care

Most of the proposed amendments to the hospice inpatient care rules are clarifying technical edits. In addition, rule language that unnecessarily duplicates requirements enforced by other entities has been removed. Building and Electrical Code references have been updated where older versions have been superseded. These changes are not expected to have an impact. This analysis will focus on the substantive changes affecting patients, facilities, and the agency.

Substantive changes to the facility requirements in these rules include:

- Central bathing requirements
- Toilet room requirements
- Sink and faucet specifications
- Nurses calling systems specifications, and
- Equivalency requirements

Rule .1201 – Requirements for Hospice Inpatient Units

The agency is proposing to readopt this rule with substantive changes for clarity and accuracy. Paragraph (c) is revised to remove rules .0507, .0600, .0800, .0907, .1004, .1200, and .1300 which no longer exist.

Fiscal Impact

No fiscal impact associated with the readoption of this rule. Under the existing Rule .1201, hospice inpatient units in licensed nursing facilities are required to meet the requirements of 10A NCAC 13D with the exception of rules .0507, .0600, .0800, .0907, .1004, .1200, and .1300.

Removing these rules since they no longer exist will not change the requirement for hospice inpatient units in licensed nursing facilities to meet the remaining portions of 10A NCAC 13D.

Rule .1204 – Additional Patient Care Area Requirements for Hospice Inpatient Units

The agency is proposing to readopt this rule with substantive changes. Changes to the proposed Rule .1204 are listed below:

- Paragraph (c)(1) adds the requirement for sinks in toilet rooms to be trimmed with valves that can be operated without the use of hands. Operating sinks without the use of hands limits the spread of bacteria or germs, keeping sinks and faucets more hygienic. This function can be achieved by equipping sinks with blade handles, electronic faucets, or other hands-free devices. The added requirement for faucets that depend on the building's electrical service for operation to be connected to the essential electrical system, or faucets that depend on batteries to have a maintenance policy to keep extra batteries is to ensure hand washing facilities are available at all time. Inpatient hospice facilities must meet the requirements of Rule .1208 which requires an essential electrical system. There will be negligible impact to connect faucets that depend on the building's electrical service to the essential electrical system because the essential electrical system is already a requirement for licensing and participation in CMS requirements. Having to have a maintenance policy for battery operated faucets will have no impact for inpatient hospice facilities due to the requirements of an essential electrical system. An additional battery system would be redundant. Providing hands-free devices is common industry standard for sinks used by patients and staff.

- Paragraph (c)(4) was revised to limit the number of beds (patients) served by a toilet room to not more than four beds (patients). The Interpretive Guideline for 42 CFR 418.110(f)[1] states that "Each patient's room must accommodate no more than two patients and their family members." As a result of these limitations on the number of patients in a patient room, the maximum number of beds (patients) served by an adjoining bathroom is limited to four beds (patients). This rule was changed for clarity to coincide with requirements of Rule .1204 Paragraph (a) and CMS requirements.

- Paragraph (c)(5) was revised to clarify the number of central bathing areas required in a facility. The existing Rule .1204 provides requirements for central bathing areas. However, the requirements are not descriptive. The proposed language rearranged to provide clarity of the requirements. In Paragraph (c)(5)(B), proposed language was added to provide optional devices in central bathing areas. These optional devices can be either a bathtub, a manufactured walk-in bathtub, a similar manufactured bathtub designed for easy transfer of patients and residents into the tub or, a shower stretcher accessible area.

[1] The Centers for Medicare and Medicaid Services, *State Operations Manual Appendix M Guidance to Surveyors: Hospice*, February 2020, SOM (cms.gov).

In Paragraph (c)(5)(C), proposed language was added to require a roll-in shower in central bathing areas if each bedroom in the facility does not provide one. The proposed language was added to read the same as 10A NCAC 13D .3201 in the Rules for Licensing Nursing Homes.

- In Paragraph (c)(5)(E), the propose rule was added to add individual cubicle curtains enclosing the toilet, tub and shower in central bathing areas. The addition of cubical curtains provides privacy for patients when using toilets, tubs, and showers. The Construction Section currently requires cubicle curtains at toilets, tubs and showers located in a central bathing room even though the rule language does not specifically require it. All current facilities already meet this requirement, either because they are CMS certified and have to comply with federal regulations or because of their upscale facilities. Adding this requirement to the rule now notifies a future facility prior to submittal of plans for review that cubicle curtains are required. Given that this is now an industry norm in North Carolina, it is highly unlikely that this addition would create an extra cost that would not exist in the absence of this rule amendment.

- Paragraph (d) was revised to provide clarity on requirements for the medication preparation area, clean utility room, and soiled utility room. The existing Rule .1204 provides requirements for each of these rooms. The proposed revisions reorganized the way requirements are presented by providing them in list form. Paragraphs (d)(1)(F), (d)(2)(C), and (d)(3)(C) adds the requirement for sinks in these rooms to be trimmed with valves that can be operated without the use of hands. Operating sinks without the use of hands limits the spread of bacteria or germs, keeping sinks and faucets more hygienic. This function can be achieved by equipping sinks with blade handles, electronic faucets, or other hands-free devices. The added requirement for faucets that depend on the building's electrical service for operation to be connected to the essential electrical system, or faucets that depend on batteries to have a maintenance policy to keep extra batteries is to ensure hand washing facilities are available at all time. Inpatient hospice facilities must meet the requirements of Rule .1208 which requires an essential electrical system. There will be negligible impact to connect faucets that depend on the building's electrical service to the essential electrical system because the essential electrical system is already a requirement for licensing. Having to have a maintenance policy for battery operated faucets will have no impact for inpatient hospice facilities due to the requirements of an essential electrical system. An additional battery system would be redundant.

Impact

Federal Impact

No fiscal impact associated with the readoption of this rule.

State Impact

No fiscal impact associated with the readoption of this rule.

Nursing Home Providers

The readoption of this rule would result in a fiscal impact to nursing home providers related to the following paragraphs:

- Paragraph (c)(5)(B) and Paragraph (c)(5)(C) adds the requirements for optional bathroom devices in central bathing areas. The addition of a walk-in bathtub or similar manufactured bathtub to a central bathing area is estimated to cost between $10,000 and $20,000 per tub. If the design provided a stretcher accessible bathing area, the cost is estimated between $3,000 and $4000 for a stretcher designed for use in a shower.[2] The fiscal impact will depend on the device installed in central bathing areas.

Rule .1205 – Furnishings for Hospice Inpatient Care

The agency is proposing to readopt this rule with substantive changes to provide technical edits and clarifications. The changes are related to reorganizing and reformatting the rule to make it easier to use. Paragraph(b)(1)(D) adds the requirement for a sink for the nourishment station trimmed with valves that can be operated without the use of hands. Operating sinks without the use of hands limits the spread of bacteria or germs, keeping sinks and faucets more hygienic. This function can be achieved by equipping sinks with blade handles, electronic faucets, or other hands-free devices. The added requirement for faucets that depend on the building's electrical service for operation to be connected to the essential electrical system, or faucets that depend on batteries to have a maintenance policy to keep extra batteries is to ensure hand washing facilities are available at all time. Inpatient hospice facilities must meet the requirements of Rule .1208 which requires an essential electrical system. There will be negligible impact to connect faucets that depend on the building's electrical service to the essential electrical system because the essential electrical system is already a requirement for licensing. Having to have a maintenance policy for battery operated faucets will have no impact for inpatient hospice facilities due to the requirements of an essential electrical system. An additional battery system would be redundant.

Impact

No fiscal impact associated with the readoption of this rule.

[2] David R. Polston, Architect, Discussion concerning central bathing designs in hospice facilities, licensed Architect, (January 2020).

Rule .1208 – Hospice Inpatient Requirements for Emergency Electrical Service

The agency is proposing to readopt this rule with substantive changes. The existing Rule .1208 provides requirements for emergency electrical service. The proposed changes are technical updates to the language of the rule due to changes in the North Carolina State Electrical Code and the 2012 NFPA 99 – *Health Care Facilities Code*. Inpatient hospice facilities must meet the requirements of the both the North Carolina State Electrical Code and 2012 NFPA 99.

Impact

No fiscal impact associated with the readoption of this rule.

Rule .1209 – Hospice Inpatient Requirements for General Electrical

The agency is proposing to amend this rule. The proposed changes are technical changes to update the rules based on the updated changes in the North Carolina State Electrical Code and the 2012 NFPA 99 – *Health Care Facilities Code*. Due to the more stringent requirements in the North Carolina State Electrical Code and the 2012 NFPA 99, inpatient hospice facilities must meet these minimum requirements anyway.

Impact

No fiscal impact associated with the readoption of this rule.

Rule .1210 – Other Hospice Inpatient Requirements

The agency is proposing to amend this rule. The proposed changes are technical changes to provide clarity of this rule. The existing Rule .1210 requires a calling system to be provided. The proposed changes clarify the placement of nurses' calling devices, and how the nurses' calling system is to function. The changes clarify the patient call station must be within reach of the patient lying on the bed, for patients lying on the floor, and notifies staff via visual and audible notifications. The proposed changes are industry standards for a nurses' calling system.

Impact

No fiscal impact associated with the readoption of this rule.

Rule .1212 – Application of Physical Plant Requirements

The agency is proposing to readopt this rule with substantive changes. The proposed changes are technical changes to provide clarity of this rule. The existing Rule .1212 provides the ability to request an equivalency to allow for alternate methods, procedure, design criteria or functional variations from the requirements of the rules in this Section. The proposed changes are to clarify

the minimum documentation that must be submitted in order to evaluate the request. The documentation listed in this rule reflects current procedures of the Construction Section.

Impact

No fiscal impact associated with the readoption of this rule.

Summary

For 10A NCAC 13K .1109, .1112, .1113, .1114, and .1115, there will be no fiscal impact to any affected persons with the readoption of these rules.

For 10A NCAC 13K .1201, .1205, .1206, .1207, .1208, .1209, .1210, .1211, and .1212., the rule changes being proposed will provide residents with non-quantifiable benefits. These non-quantifiable benefits could include improvements to health and safety, and maintenance of their privacy and dignity.

For 10A NCAC 13 K .1204, there will also be some fiscal impact to the nursing home providers. The fiscal impact to nursing home providers depends on the type of bathing device to be provided in central bathing areas. The type of bathing device chosen might cause an impact on initial construction costs. The initial cost of providing a bathing device as described in the proposed revised rule, can range from $3,000 to $20,000. However, this cost would be offset by the cost of bathing devices installed per the existing rule. Without knowledge of the cost of bathing devices currently used, the total net cost impact cannot be estimated.

Appendix

10A NCAC 13K .1109 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1109 RESIDENT CARE AREAS

(a) ~~Resident rooms shall meet the following requirements:~~ A facility shall meet the following requirements for resident bedrooms:

(1) ~~There shall be private or semiprivate rooms;~~ private bedroom with not less than 100 square feet of floor area or semi-private bedroom with not less than 80 square feet of floor area per bed shall be provided;

(2) ~~Infants~~ infants and small children shall not ~~be assigned to~~ share a ~~room~~ bedroom with an adult resident unless requested by ~~residents~~ the resident and families;

(3) ~~Each resident room~~ each bedroom shall ~~contain at least~~ be furnished with a bed, a mattress protected by waterproof material, a mattress pad, a pillow, and ~~a chair;~~ one chair per resident;

(4) ~~Each resident room shall have a minimum of 48 cubic feet of closet space or wardrobe for clothing and personal belongings that provides security and privacy for each resident. Each resident room shall be equipped with a towel rack for each individual;~~ each bedroom shall be provided with one closet or wardrobe per bed. Each closet or wardrobe shall have clothing storage space of not less than 48 cubic feet per bed with one-half of this space for hanging clothes;

(5) ~~Each resident~~ each bedroom shall:

(A) be located at or above grade level;

(B) ~~have provisions to ensure visual privacy for treatment or visiting;~~ be provided with a cubicle curtain enclosing each bed to ensure visual privacy; and

(C) be equipped with a towel rack for each resident;

(6) ~~Artificial lighting shall be provided sufficient~~ each bedroom shall provide lighting for treatment and non-treatment needs, 50 ~~foot candles~~ foot-candles for ~~treatment,~~ treatment needs, and 35 ~~foot candles~~ foot-candles for non-treatment ~~areas;~~ needs; and

(7) ~~A room where access is through a bathroom, kitchen or another bedroom will not be approved for a resident's bedroom.~~ no resident bedroom shall be accessed through a bathroom, kitchen, or another bedroom.

(b) ~~Bathrooms shall meet the following requirements:~~ A facility shall meet the following requirements for bathrooms:

(1) ~~Bathroom facilities~~ bathrooms shall be ~~conveniently~~ directly accessible to ~~resident rooms.~~ each resident bedroom without going through the general corridors. One bathroom may serve up to four ~~residents and staff.~~ residents. ~~Minimum size of any bathroom shall be 18 square feet.~~ The ~~door~~ bathroom doorway shall ~~be at least 32 inches wide.~~ be a minimum 32-inch clear opening;

(2) ~~The~~ each bathroom shall be furnished with the following:

(A) a toilet with grab bars;

(B) ~~lavatory with four inch wrist blade controls;~~ a sink trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four inches in length. If the sink faucet depends on the building electrical service for operation, the faucet must have an emergency power source or battery backup capability. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets;

(C) a mirror;

(D) soap, paper towel dispensers, and waste paper receptacle with a removable impervious liner; and

~~(E) water closet; and~~

~~(F)~~(E) a tub or shower.

(c) ~~Space shall be provided for:~~ Each facility shall provide:

(1) ~~charting, storage of supplies and personal effects of staff;~~ an area for charting;

(2) ~~the storage of resident care equipment;~~ storage provisions for personal effects of staff;

(3) ~~housekeeping equipment and cleaning supplies;~~ storage areas for supplies and resident care equipment;

(4) ~~storage of test reagents and disinfectants distinct from medication;~~ storage area(s) for housekeeping equipment and cleaning supplies;

(5) ~~locked medication storage and preparation; and~~ a medication preparation area with a counter, a sink trimmed with valves that can be operated without hands, locked medication storage, and a double locked narcotic storage area under visual control of staff. If the sink is equipped with blade handles, the blade handles shall not be less than four inches in length. If the sink faucet depends on the building electrical service for operation, the faucet must have an emergency power source or battery backup capability. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets;

(6) ~~drugs requiring refrigeration. They may be stored in a separate locked box in the refrigerator or in a lockable drug only refrigerator, capable of maintaining a temperature range of 36 degrees F (2 degrees C) to 46 degrees F (8 degrees C). The storage and accountability of controlled substances shall be in accordance with the North Carolina Controlled Substances Act, Article 5 of Chapter 90 of the General Statutes.~~ a lockable refrigerator for drug storage only or a separate locked box in a facility refrigerator. The refrigerator must be capable of maintaining a temperature range of 36 degrees F (2 degrees C) to 46 degrees F (8 degrees C);

(7) a kitchen with:

(A) a refrigerator;

(B) a cooking appliance ventilated to the outside;

(C) a 42- inch minimum double-compartment sink and domestic dishwashing machine capable of sanitizing dishes with 160 degrees F water; and

(D) storage space for non-perishables;

(8) a separate dining area measuring not less than 20 square feet per resident bed;

(9) a recreational and social activities area with not less than 150 square feet of floor area exclusive of corridor traffic;

(10) a nurses'calling system shall be provided:

(A) in each resident bedroom for each resident bed. The call system activator shall be such that they can be activated with a single action and remain on until deactivated by staff at the point of origin. The call system activator shall be within reach of a resident lying on the bed. In rooms containing two or more call system activators, indicating lights shall be provided at each calling station;

(B) nurses' calling systems which provide two-way voice communication shall be equipped with an indicating light at each calling station which lights and remains lighted as long as the voice circuit is operating;

(C) a nurses' call emergency activator shall be proved at each residents' use toilet fixture, bath, and shower. The call system activator shall be accessible to a resident lying on the floor; and

(D) calls shall register with the floor staff and shall activate a visible signal in the corridor at the resident's door. In multi-corridor units, additional visible signals shall be installed at corridor intersections;

(11) heating and air conditioning equipment that can maintain a temperature range between 68 degrees and 80 degrees Fahrenheit, even upon loss of utility power.

~~(d) Kitchen and dining areas shall have:~~

~~(1) a refrigerator;~~

~~(2) a cooking unit ventilated to the outside;~~

~~(3) a 42 inch minimum double compartment sink and domestic dishwashing machine capable of sanitizing dishes with 160 degrees F. water;~~

~~(4) dining space of 20 square feet per resident; and~~

~~(5) storage space for non-perishables.~~

~~(e) Other areas shall include:~~

~~(1) a minimum of 150 square feet exclusive of corridor traffic for recreational and social activities;~~

~~(2) an audible and accessible call system furnished in each resident's room and bathroom; and~~

~~(3) heating and air cooling equipment to maintain a comfort range between 68 degrees and 80 degrees Fahrenheit.~~

History Note: *Authority G.S. 131E-202;*
Eff. June 1, 1991;
Amended Eff. February 1, ~~1995.~~ 1995;

Readopted Eff. October 1, 2021.

10A NCAC 13K .1112 is proposed for amendment as follows:

10A NCAC 13K .1112 DESIGN AND CONSTRUCTION

(a) ~~Hospice residences and inpatient units~~ A new facility or remodeling of an existing facility ~~must~~ shall meet the requirements of the North Carolina State Building ~~Code~~ Codes, which are incorporated by reference, including all subsequent amendments and editions, in effect at the time of licensure, construction, additions, alterations or repairs. Copies of these codes may be purchased from the International Code Council online at https://shop.iccsafe.org/ at a cost of eight hundred fifty-eight dollars ($858.00) or accessed electronically free of charge at https://codes.iccsafe.org/codes/north-carolina. Existing licensed facilities shall meet the requirements of the North Carolina State Building Codes in effect at the time of licensure, construction or remodeling.

(b) Each facility shall be planned, constructed, and equipped to support the services to be offered in the facility.

(c) Any existing building converted to a hospice facility shall meet all requirements of a new facility.

(d) The sanitation, water supply, sewage disposal, and dietary facilities ~~must comply with the rules of the Commission for Public Health.~~ shall meet the requirements of Rule 15A NCAC 18A .1300, which is incorporated by reference including subsequent amendments and editions.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, ~~2018.~~ 2018;
Amended Eff. October 1, 2021.

10A NCAC 13K .1113 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1113 PLANS AND SPECIFICATIONS

(a) When construction or remodeling of a facility is planned, ~~final working drawings and specifications must~~ one copy of construction documents and specifications shall be submitted by the owner or the owner's appointed representative to the Department ~~of Health and Human Services, Division of Health Service Regulation~~ for review and approval. ~~Schematic~~ Schematic design drawings and ~~preliminary working~~ design development drawings ~~shall~~ may be submitted ~~by the owner prior to the required submission of final working drawings.~~ for approval prior to the required submission of construction documents. ~~The Department shall forward copies of each submittal to the Department of Insurance and Division of Environmental Health for review and approval. Three copies of the plans shall be provided at each submittal.~~

(b) ~~Construction work shall not be commenced until written approval has been given by the Department.~~ Approval of ~~final plans~~ construction documents and specifications shall be obtained from the Department prior to licensure. Approval of construction documents and specifications shall expire one year ~~from the date granted unless a contract for the construction has been signed prior to the expiration date.~~ after the date of approval unless a building permit for the construction has been obtained prior to the expiration date of the approval of construction documents and specifications.

(c) If an approval expires, ~~a~~ renewed approval shall be issued by the Department, provided revised ~~plans~~ construction documents and specifications meeting ~~all current regulations, codes, and~~ the standards established in Sections .1100 and .1200 of this Subchapter are ~~submitted.~~ submitted by the owner or owner's appointed representative and reviewed by the Department.

(d) ~~Completed construction shall conform to the minimum standards established in these Rules.~~ Any changes made during construction shall require the approval of the Department to ensure compliance with the standards established in Sections .1100 and .1200 of this Subchapter.

(e) ~~The owner or designated agent shall notify the Department when actual construction starts and at points when construction is 75 percent and 90 percent complete and upon final completion, so that periodic and final inspections can be performed.~~ Completed construction or remodeling shall conform to the standards established in Sections .1100 and .1200 of this Subchapter. Construction documents and building construction, including the operation of all building systems, shall be approved in writing by the Department prior to licensure or patient and resident occupancy.

(f) The owner or owner's ~~designated agent~~ appointed representative shall ~~submit for approval by the Department all alterations or remodeling changes which affect the structural integrity of the building, functional operation, fire safety or which add beds or facilities over those for which the facility is licensed.~~ notify the Department in writing either by U.S. Mail or e-mail when the construction or remodeling is complete.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, 1991;
Amended Eff. February 1, ~~1996.~~ 1996;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1114 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1114 PLUMBING

~~(a) The water supply shall be designed, constructed and protected so as to assure that a safe, potable and adequate water supply is available for domestic purposes in compliance with the North Carolina State Building Code.~~

~~(b) All plumbing in the residence or unit shall be installed and maintained in accordance with the North Carolina State Plumbing Code. All plumbing shall be maintained in good repair and free of the possibility of backflow and backsiphonage, through the use of vacuum breakers and fixed air gaps, in accordance with state and local codes.~~

~~(c)~~ For ~~homes~~ hospice residential facilities with five or more residents, a 50-gallon quick recovery water heater is required. For ~~homes~~ hospice residential facilities with fewer than five residents, a 40-gallon quick recovery water heater is required.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, ~~1991.~~ 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1115 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1115 WASTE DISPOSAL

(a) Sewage shall be discharged into a public sewer system, or ~~if such is not available, it~~ in the absence of a public sewer system, sewage shall be disposed of in a manner approved by the North Carolina ~~Division of Environmental Health.~~ Department of Health and Human Services, Division of Public Health, Environmental Health Section.

(b) Garbage and rubbish shall be stored in impervious containers in ~~such~~ a manner as ~~not to become a nuisance or a health hazard.~~ to prevent insect breeding and public health nuisances. ~~A sufficient number of impervious~~ Impervious containers with tight-fitting lids shall be provided and kept clean and in good repair. ~~Refuse~~ Garbage shall be removed from the outside storage at least once a week to a disposal site approved by the local health ~~department.~~ department having jurisdiction.

(c) The ~~home~~ facility or unit shall ~~be maintained free of infestations of insects and rodents, and all openings to the outside shall be screened.~~ take measures to keep insects, rodents, and other vermin out of the residential care facility. All openings to the outer air shall be protected against the entrance of flying insects by screens, closed doors, closed windows, or other means.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, ~~1991.~~ 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1116 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1116 APPLICATION OF PHYSICAL PLANT REQUIREMENTS

The physical ~~plan~~ plant requirements for each hospice residential facility or unit shall be applied as follows:

(1) New construction shall comply with all the requirements of ~~Section .1100 of this Subchapter;~~ this Section;

(2) ~~Existing~~ Except where otherwise specified, existing buildings shall meet the licensure and code requirements in effect at the time of licensure, construction, ~~alteration~~ alteration, or ~~modification;~~ modification.

~~(3) New additions, alterations, modifications, and repairs shall meet the technical requirements of Section .1100 of this Subchapter; however, where strict conformance with current requirements would be impracticable, the authority having jurisdiction may approve alternative measures where the facility can demonstrate to the Department's satisfaction that the alternative measures do not reduce the safety or operating effectiveness of the facility;~~

~~(4)~~(3) Rules contained in ~~Rule .1109 of~~ this Section are minimum requirements and are not intended to prohibit buildings, ~~systems~~ systems, or operational conditions that exceed minimum ~~requirements;~~ requirements.

~~(5)~~(4) ~~Equivalency: Alternate methods, procedures, design criteria, and functional variations from the physical plant requirements, because of extraordinary circumstances, new programs, or unusual conditions, may be approved by the authority having jurisdiction when the facility can effectively demonstrate to the Department's satisfaction that the intent of the physical plant requirements are met and that the variation does not reduce the safety or operational effectiveness of the facility; and~~ The Division may grant an equivalency to allow alternate methods, procedures, design criteria or functional variation from the requirements of this Rule and the rules contained in this Section. The equivalency may be granted by the Division when a governing body submits a written equivalency request to the Division that states the following:

(a) the rule citation and the rule requirement that will not be met due to strict conformance with current requirements would be impractical, extraordinary circumstances, new programs, or unusual conditions;

(b) the justification for the equivalency; and

(c) how the proposed equivalency meets the intent of the corresponding rule requirement.

(5) In determining whether to grant an equivalency request the Division shall consider whether the request will reduce the safety and operational effectiveness of the facility. The governing body shall maintain a copy of the approved equivalence issued by the Division.

(6) Where ~~rules or codes~~ rules, codes, or standards have any conflict, the more stringent requirement shall apply.

History Note: *Authority G.S. 131E-202;*
Eff. February 1, ~~1996.~~ 1996;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1201 is proposed for readoption with substantive changes as follows:

SECTION .1200 - HOSPICE INPATIENT CARE

10A NCAC 13K .1201 REQUIREMENTS FOR HOSPICE INPATIENT UNITS

(a) Hospice inpatient facilities or units ~~must~~ shall conform to the rules outlined in ~~10A NCAC 13K~~ Sections .0100 through .1100 of this Subchapter and ~~those in this Section.~~ the rules of this Section.

(b) Hospice inpatient units located in a licensed hospital shall meet the requirements of 10A NCAC ~~13B with the exception of:~~ 13B, which is incorporated by reference with subsequent amendments and editions except for rules: 10A NCAC 13B .1912, .1919, .1922, and .1923.

(c) Hospice inpatient units located in a licensed nursing facility shall meet the requirements of 10A NCAC ~~13D with the exception of: 10A NCAC 13D .0507, .0600, .0800, .0907, .1004, .1200 and .1300.~~ 13D, which is incorporated by reference with subsequent amendments and editions.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, ~~1991.~~ 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1204 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1204 ADDITIONAL PATIENT CARE AREA REQUIREMENTS FOR HOSPICE INPATIENT UNITS

(a) ~~The floor area of a single bedroom shall not be less than 100 square feet and the floor area of a room for more than one bed shall not be less than 80 square feet per bed. The 80 square feet and 100 square feet requirements shall be exclusive of closets, toilet rooms, vestibules or wardrobes.~~ A facility shall meet the following requirements for patient bedrooms:

(1) private bedrooms shall be provided with not less than 100 square feet of floor area;

(2) semi-private bedrooms with not less than 80 square feet of floor area per bed; and

(3) floor space for closets, toilet rooms, vestibules, or wardrobes shall not be included in the floor areas required by this Paragraph.

(b) ~~The total space set aside for dining, recreation and other common uses shall not be less than 30 square feet per bed. Physical therapy and occupational therapy space shall not be included in this total.~~ A facility shall meet the following requirements for dining, recreation, and common use areas:

(1) floor space for dining, recreation, and common use shall not be less than 30 square feet per bed;

(2) the dining, recreation, and common use areas required by this Paragraph may be combined; and

(3) floor space for physical and occupational therapy shall not be included in the areas required by this Paragraph.

(c) ~~A toilet room shall be directly accessible from each patient room and from each central bathing area without going through the general corridor. One toilet room may serve two patient rooms but not more than eight beds. The lavatory may be omitted from the toilet room if one is provided for each 15 beds not individually served. There shall be a wheelchair and stretcher accessible central bathing area for staff to bathe a patient who cannot perform this activity independently. There shall be at least one such area per each level in a multi-level facility.~~ A facility shall meet the following requirements for toilet rooms, tubs, showers, and central bathing areas:

(1) a toilet room shall contain a toilet fixture and a sink trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four inches in length. If the sink faucet depends on the building electrical service for operation, the faucet shall be connected to the essential electrical system. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets;

(2) if a sink is provided in each bedroom, the toilet room is not required to have a sink;

(3) a toilet room shall be accessible from each bedroom without going through the general corridors;

(4) one toilet room may serve two bedrooms, but not more than four beds; and

(5) a minimum of one central bathing area. In multi-level facilities, each patient floor shall contain a minimum of one central bathing area. Central bathing area(s) shall be provided with the following:

(A) wheelchair and stretcher accessible for staff to bathe a patient who cannot perform this activity independently;

(B) a bathtub, a manufactured walk-in bathtub, a similar manufactured bathtub designed for easy transfer of patients and residents into the tub, or a shower designed and equipped for unobstructed ease of stretcher entry and bathing on three sides. Bathtubs shall be accessible on three sides. Manufactured walk-in bathtubs or a similar manufactured bathtub shall be accessible on two sides;

(C) a roll-in shower designed and equipped for unobstructed ease of shower chair entry and use. If a bathroom with a roll-in shower designed and equipped for unobstructed ease of shower chair entry adjoins each bedroom in the facility, the central bathing area is not required to have a roll-in shower;

(D) toilet fixture and lavatory; and

(E) an individual cubicle curtain enclosing each toilet, tub, and shower. A closed cubicle curtain at one of these plumbing fixtures shall not restrict access to the other plumbing fixtures.

(d) For each nursing unit ~~or fraction thereof~~ on each floor, the following shall be provided:

(1) ~~an adequate medication preparation area with counter, sink with four inch handles, medication refrigerator, eye level medication storage, cabinet storage, and double locked narcotic storage room, located adjacent to the nursing station or under visual control of the nursing station;~~ a medication preparation area with:

(A) a counter;

(B) a double locked narcotic storage area under the visual control of nursing staff;

(C) a medication refrigerator;

(D) medication storage visible by staff standing on the floor;

(E) cabinet storage; and

(F) a sink trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four inches in length. If the sink faucet depends on the building electrical service for operation, the faucet shall be connected to the essential electrical system. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets;

(2) ~~a clean utility room with counter, sink with four inch handles, wall and under counter storage;~~ a clean utility room with:

(A) a counter;

(B) storage; and

(C) a sink trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four inches in length. If the sink faucet depends on the building electrical service for operation, the faucet shall be connected to the essential electrical system. If the sink has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets;

(3) ~~a soiled utility room with counter, sink with four inch handles, wall and under counter storage, a flush rim clinical sink or water closet with a suitable device for cleaning bedpans and a suitable means for washing and sanitizing bedpans and other utensils;~~ a soiled utility room with:

(A) a counter;

(B) storage; and

(C) a sink trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four inches in length. If the sink faucet depends on the building electrical service for operation, the faucet shall be connected to the essential electrical system. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets. The soiled utility room shall be equipped for the cleaning and sanitizing of bedpans as required by Rule 15A NCAC 18A .1312, which is incorporated by reference including subsequent amendments and editions;

(4) a nurses' toilet and locker space for personal belongings;

(5) an audiovisual nurse-patient call system arranged to ensure that a patient's call in the facility ~~is noted at a staffed station;~~ notifies and directs staff to the location where the call was activated;

(6) a soiled linen storage ~~area;~~ room with a hand sanitizing dispenser. If the soiled linen storage room is combined with the soiled utility room, a separate soiled linen storage room is not required;

(7) a clean linen storage room ~~area; and~~ provided in one or more of the following:

(A) a separate linen storage room;

(B) cabinets in the clean utility room; or

(C) a linen closet; and

(8) ~~at least one~~ a janitor's closet.

(e) Dietary and laundry each ~~must~~ shall have a separate janitor's closet.

(f) Stretcher and wheelchair storage shall be provided.

(g) ~~Bulk~~ The facility shall provide storage ~~shall be provided~~ at the rate of not less than five square feet of floor area per licensed bed. This storage space shall:

(1) be used by patients to store personal belongings and suitcases;

(2) be either in the facility or within 500 feet of the facility on the same site; and

(3) be in addition to the other storage space required by this Rule.

(h) Office space shall be provided for ~~persons with administrative responsibilities for the unit.~~ business transactions. Office space shall be provided for persons holding the following positions if these positions are provided:

(1) administrator;

(2) director of nursing;

(3) social services director;

(4) activities director; and

(5) physical therapist.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, 1991;
Amended Eff. February 1, ~~1996.~~ 1996;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1205 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1205 FURNISHINGS FOR HOSPICE INPATIENT CARE

(a) ~~Handgrips shall be provided for~~ A facility shall provide handgrips at all toilet and bath facilities used by patients. Handrails shall be provided on both sides of all corridors where corridors are defined by walls and used by patients.

(b) For each nursing unit ~~or fraction thereof~~ on each floor, the following shall be provided:

(1) a nourishment station ~~with work space, cabinet, and refrigerated storage, a small stove or hotplate in an area physically~~ separated from the nurses' ~~station; and~~ station with:

(A) work space;

(B) cabinets;

(C) refrigerated storage;

(D) a sink trimmed with valves that can be operated without hands. If the sink is equipped with blade handles, the blade handles shall not be less than four inches in length. If the sink faucet depends on the building electrical service for operation, the faucet shall be connected to the essential electrical system. If the faucet has battery operated sensors, the facility shall have a maintenance policy to keep extra rechargeable or non-rechargeable batteries on premises for the faucets;

(E) a small stove, microwave, or hot plate; and

(2) ~~one~~ a nurses' station ~~consisting of adequate desk space for writing, storage space for office supplies and storage space for patients' records.~~ with:

(A) desk space for writing;

(B) storage space for office supplies; and

(C) storage space for patients' records.

(c) ~~Flameproof privacy screens or curtains shall be provided~~ A facility shall provide flame resistant cubicle curtains in multi-bedded rooms.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, ~~1991.~~ 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1206 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1206 HOSPICE INPATIENT FIRE AND SAFETY REQUIREMENTS

~~(a) A new facility shall meet the requirements of the current North Carolina State Building Code and the following additional requirements:~~

~~(1) Where nursing units are located on the same floor with other departments or services, the facility shall be designed to provide separation from the other departments or services with a smoke barrier.~~

~~(2) Horizontal exits are not permitted in any new facility.~~

~~(3) An addition to an existing facility shall meet the same requirements as a new facility except that in no case shall more than one horizontal exit be used to replace a required exit to the outside. For all construction, an emergency generating set, including the prime mover and generator, shall be located on the premises and shall be reserved exclusively for supplying the emergency electrical system.~~

~~(b)~~(a) The hospice shall establish written policies and procedures governing disaster preparedness and fire protection.

~~(c) The hospice shall have an acceptable written plan periodically rehearsed with staff with procedures to be followed in the event of an internal or external disaster, and for the care of casualties of patients and personnel arising from such disasters.~~

(b) The hospice shall have detailed written plans and procedures to meet potential emergencies and disasters, including fire and severe weather.

(c) The plans and procedures shall be made available upon request to local or regional emergency management offices.

(d) The facility shall provide training for all employees in emergency procedures upon employment and annually.

(e) The facility shall conduct unannounced drills using the emergency procedures.

(f) The facility shall ensure that:

(1) the patients' environment remains as free of accident hazards as possible; and

(2) each patient receives adequate supervision and assistance to prevent accidents.

~~(d)~~(g) The fire protection plan shall include:

(1) instruction for all personnel in use of alarms, ~~fire fighting~~ firefighting equipment, methods of fire containment, evacuation ~~routes and~~ routes, procedures for calling the fire ~~department~~ department, and the assignment of specific tasks to all personnel in response to an alarm; and

(2) fire drills for each shift of personnel at least quarterly.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, ~~1991.~~ 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1207 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1207 HOSPICE INPATIENT REQUIREMENTS FOR HEATING/AIR CONDITIONING

~~Heating and cooling systems shall meet the current American Society of Heating, Refrigeration, and Air Conditioning Engineers Guide and National Fire Protection Association Code 90A, which is hereby adopted by reference pursuant to G.S. 150B-14(c), with the following modification:~~ A facility shall provide heating and cooling systems complying with the following:

(1) ~~Soiled linen, bathrooms, janitor closets and soiled utility rooms must have negative pressure with relationship to adjacent areas.~~ The American National Standards Institute and American Society of Heating, Refrigerating, and Air Conditioning Engineers Standard 170: Ventilation of Health Care Facilities, which is incorporated by reference, including all subsequent amendments and editions, and may be purchased for a cost of ninety-four dollars ($94.00) online at https://www.techstreet.com/ashrae/index.html. This incorporation does not apply to Section 9.1, Table 9-1 Design Temperature for Skilled Nursing Facility. The environmental temperature control systems shall be capable of maintaining temperatures in the facility at 71 degrees F. minimum in

the heating season and a maximum of 81 degrees F. during non-heating season, even upon loss of utility power; and

(2) ~~Clean linen, clean utility and drug rooms must have positive pressure with relationship to adjacent areas.~~ The National Fire Protection Association 90A: Standard for the Installation of Air-Conditioning and Ventilating Systems, which is incorporated by reference, including all subsequent amendments and editions, and may be purchased at a cost of fifty dollars and fifty cents ($50.50) from the National Fire Protection Association online at http://www.nfpa.org/catalog/ or accessed electronically free of charge at http://www.nfpa.org/aboutthecodes/AboutTheCodes.asp?DocNum=90A.

~~(3) All areas not covered in Paragraphs (1) and (2) of this Rule must have neutral pressure.~~

History Note: *Authority G.S. 131E-202;*
Eff. June 1, ~~1991.~~ 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1208 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1208 HOSPICE INPATIENT ~~REQUIREMENTS/EMERGENCY~~ REQUIREMENTS FOR EMERGENCY ELECTRICAL SERVICE

~~Emergency electrical service shall be provided~~ A facility shall provide an emergency electrical service for use in the event of failure of the normal electrical service. This emergency electrical service shall ~~be made up as follows:~~ consist of the following:

(1) In any existing ~~facility, the following must be provided:~~ facility:

(a) type 1 or 2 emergency lights as required by the North Carolina State Building ~~Code;~~ Codes: Electrical Code;

(b) additional emergency lights for all ~~nursing stations,~~ nurses' stations required by Rule .1205(b)(2) of this Section, ~~drug~~ medication preparation areas required by Rule .1204(d)(1) of this Section, ~~and~~ storage areas, and for the telephone switchboard, if applicable;

(c) one or more portable battery-powered lamps at each ~~nursing station;~~ nurses' station; and

(d) a ~~suitable~~ source of emergency power for life-sustaining ~~equipment~~ equipment, if the facility admits or cares for occupants needing such equipment, to ensure continuous operation with on-site fuel storage for a minimum of 72 hours.

(2) ~~Any addition to an existing facility shall meet the same requirements as new construction.~~ An emergency power generating set, including the prime mover and generator, shall be located on the premises and shall be reserved exclusively for supplying the essential electrical system. For the purposes of this Rule, the "essential electrical system" means a system comprised of alternate

sources of power and all connected distribution systems and ancillary equipment, designed to ensure continuity of electrical power to designated areas and functions of a facility during disruption of normal power sources, and also to minimize disruption within the internal wiring system as defined by the North Carolina State Building Codes: Electrical Code.

(3) ~~Any conversion of an existing building such as a hotel, motel, abandoned hospital or abandoned school, shall meet the same requirements for emergency electrical services as required for new construction.~~ Emergency electrical services shall be provided as required by the North Carolina State Building Codes: Electric Code with the following modification: Section 517.10(B)(2) of the North Carolina State Building Codes: Electrical Code shall not apply to new facilities.

(4) ~~Battery-powered corridor lights shall not replace the requirements for the emergency circuit nor be construed to substitute for the generator set. Sufficient fuel shall be stored for the operation of the emergency generator for a period not less than 72 hours, on a 24 hour per day operational basis. The system shall be test run for a period of not less than 15 minutes on a weekly schedule. Records of running time shall be maintained and kept available for reference.~~

~~(5) To ensure proper evaluation of design of emergency power systems, the owner or operator shall submit with final working drawings and specifications a letter describing the policy for admissions and discharges to be used when the facility begins operations. If subsequent inspections for licensure indicate the admission policies have been changed, the facility will be required to take immediate steps to meet appropriate code requirements for continued licensure.~~

~~(6) Lighting for emergency electrical services shall be provided in the following places:~~

~~(a) exit ways and all necessary ways of approach exits, including exit signs and exit direction signs, exterior of exits exit doorways, stairways, and corridors;~~

~~(b) dining and recreation rooms;~~

~~(c) nursing station and medication preparation area;~~

~~(d) generator set location, switch gear location, and boiler room, if applicable; and~~

~~(e) elevator, if required for emergency.~~

~~(7) The following emergency equipment which is essential to life, safety, and the protection of important equipment or vital materials shall be provided:~~ The following equipment, devices, and systems that are essential to life safety and the protection of important equipment or vital materials shall be connected to the equipment branch of the essential electrical system as follows:

(a) nurses' calling system;

~~(b) alarm system, including fire alarm actuated at manual stations, water flow alarm devices of sprinkler systems if electrically operated, fire detecting and smoke detecting systems, paging or speaker systems if intended for issuing instructions during emergency conditions, and alarms required for nonflammable medical gas systems, if installed;~~

~~(c)~~(b) fire pump, if installed;

~~(d)~~(c) sewerage or sump lift pump, if installed;

~~(e)~~(d) one elevator, where elevators are used for vertical transportation of patients;

~~(f)~~(e) equipment such as burners and pumps necessary for operation of one or more boilers and their necessary auxiliaries and controls, required for heating and sterilization, if installed; and

~~(g) equipment necessary for maintaining telephone service.~~

(f) task illumination of boiler rooms, if applicable.

(5) The following equipment, devices, and systems that are essential to life safety and the protection of important equipment or vital materials shall be connected to the life safety branch of the essential electrical system as follows:

(a) alarm system, including fire alarm actuated at manual stations, water flow alarm devices of sprinkler systems if electrically operated, fire detecting and smoke detecting systems, paging or speaker systems if intended for issuing instructions during emergency conditions, and alarms required for nonflammable medical gas systems, if installed; and

(b) equipment necessary for maintaining telephone service.

~~(8)~~(6) Where electricity is the only source of power normally used for ~~space heating, the emergency service~~ the heating of space, an essential electrical system shall be provided for heating of patient rooms. Emergency heating of patient rooms ~~will~~ shall not be required in areas where the facility is supplied by at least two separate generating ~~sources,~~ sources or a network distribution system with the facility feeders so routed, connected, and protected that a fault any place between the ~~generators~~ generating sources and the facility will not likely cause an ~~interruption.~~ interruption of more than one of the facility service feeders.

~~(9)~~(7) ~~The emergency~~ An essential electrical system shall be so controlled that after interruption of the normal electric power supply, the generator is brought to full voltage and frequency and connected within ~~ten~~ 10 seconds through one or more primary automatic transfer switches to all emergency lighting, alarms, ~~nurses' call,~~ and equipment necessary for maintaining telephone ~~service, and receptacles in patient corridors.~~ service. All other lighting and equipment required to be connected to the ~~emergency~~ essential electrical system shall either be connected through the ~~ten~~ 10 second primary automatic transfer switching or shall be ~~subsequently~~ connected through ~~other~~ delayed automatic or manual transfer switching. If manual transfer switching is provided, staff of the facility shall operate the manual transfer switch. ~~Receptacles~~ Electrical outlets connected to the ~~emergency~~ essential electrical system shall be ~~distinctively~~ marked for identification.

(8) Fuel shall be stored for the operation of the emergency power generator for a period not less than 72 hours, on a 24-hour per day operational basis with on-site fuel storage. The generator system shall be tested and maintained per National Fire Protection Association Health Care Facilities Code, NFPA 99, 2012 edition, which is incorporated by reference, including all subsequent amendments and editions. Copies of this code may be purchased at a cost of seventy-nine and fifty cents ($79.50) from the National Fire Protection Association - online at http://www.nfpa.org/catalog/ or accessed

electronically free of charge at http://www.nfpa.org/aboutthecodes/AboutTheCodes.asp?DocNum=99. The facility shall maintain records of the generator system tests and shall make these records available to the Division for inspection upon request.

(9) The electrical emergency service at existing facilities shall comply with the requirements established in this Section in effect at the time a license is first issued. Any remodeling of an existing facility that results in changes to the emergency electrical service shall comply with the requirements established in this Section in effect at the time of remodeling.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, ~~1991.~~ 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1209 is proposed for amendment as follows:

10A NCAC 13K .1209 HOSPICE INPATIENT REQUIREMENTS FOR GENERAL ELECTRICAL

(a) All main water supply shut off valves in the sprinkler system must be electronically supervised so that if any valve is closed an alarm will sound at a continuously manned central station.

(b) No two adjacent emergency life safety branch lighting fixtures shall be on the same circuit.

(c) Receptacles in bathrooms must have ground fault protection.

(d) Each patient bed location must be provided with a minimum of ~~four~~ eight single or ~~two~~ four duplex receptacles.

(e) Each patient bed location must be supplied by at least two branch ~~circuits.~~ circuits, one from the equipment branch and one from the normal system.

(f) The fire alarm system must be installed to transmit an alarm automatically to the fire department that is, legally committed to serve the area in which the facility is located, by the direct and reliable method approved by local ordinances.

(g) In patient areas, fire alarms shall be gongs or chimes rather than horns or bells.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, ~~2018.~~ 2018;
Amended Eff. October 1, 2021.

10A NCAC 13K .1210 is proposed for amendment as follows:

10A NCAC 13K .1210 OTHER HOSPICE INPATIENT REQUIREMENTS

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

(1) in each patient bedroom for each patient bed. The call system activator shall be such that they can be activated with a single action and remain on until deactivated by staff at the point of origin. The call system activator shall be within reach of a patient lying on the bed. In rooms containing two or more call system activators, indicating lights shall be provided at each calling station;

(2) nurses' calling systems which provide two-way voice communication shall be equipped with an indicating light at each calling station which lights and remains lighted as long as the voice circuit is operating;

(3) a nurses' call emergency activator shall be proved at each patients' use toilet fixture, bath, and shower. The call system activator shall be accessible to a patient lying on the floor; and

(4) calls shall register with the floor staff and shall activate a visible signal in the corridor at the patient's door. In multi-corridor units, additional visible signals shall be installed at corridor intersections.

(b) At least one telephone shall be available in each area to which patients are admitted and additional telephones or extensions as are necessary to ensure availability in case of need.

(c) General outdoor lighting shall be provided adequate to illuminate walkways and drive.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, 1991;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. December 22, ~~2018.~~ 2018;
Amended Eff. October 1, 2021.

10A NCAC 13K .1211 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1211 ADDITIONAL PLUMBING REQUIREMENTS/HOSPICE INPATIENT UNITS

~~For inpatient units, the hot water system shall be adequate to provide:~~

	Patient Areas	Dietary	Laundry
Gallons per hour per bed	6 ½	4	4 1/2
Temperature degrees F.	110-116	140 (min)	140 (min)

Hospice inpatient facilities or units shall provide a flow of hot water within safety ranges specified as follows:

(1) Patient Areas – 6 ½ gallons per hour per bed and at a temperature of 100 to 116 degrees F;

(2) Dietary Services – 4 gallons per hour per bed and at a minimum temperature of 140 degrees F; and

(3) Laundry Area – 4 ½ gallons per hour per bed and at a minimum temperature of 140 degrees F.

History Note: *Authority G.S. 131E-202;*
Eff. June 1, ~~1991.~~ 1991;
Readopted Eff. October 1, 2021.

10A NCAC 13K .1212 is proposed for readoption with substantive changes as follows:

10A NCAC 13K .1212 APPLICATION OF PHYSICAL PLANT REQUIREMENTS

The physical plant requirements for each hospice inpatient facility or unit shall be applied as follows:

(1) New construction shall comply with all the requirements of ~~Section .1200 of this Subchapter;~~ this Section.

(2) ~~Existing~~ Except where otherwise specified, existing buildings shall meet the licensure and code requirements in effect at the time of licensure, construction, alteration, or ~~modification;~~ modification.

~~(3) New additions, alterations, modifications, and repairs shall meet the technical requirements of Section .1100 of this Subchapter; however, where strict conformance with current requirements would be impracticable, the authority having jurisdiction may approve alternative measures where the facility can demonstrate to the Department's satisfaction that the alternative measures do not reduce the safety or operating effectiveness of the facility;~~

~~(4)~~(3) Rules contained in ~~Rule .1210 of~~ this Section are minimum requirements and are not intended to prohibit buildings, ~~systems~~ systems, or operational conditions that exceed minimum ~~requirements;~~ requirements.

~~(5)~~(4) ~~Equivalency: Alternate methods, procedures, design criteria, and functional variations from the physical plant requirements, because of extraordinary circumstances, new programs, or unusual conditions, may be approved by the authority having jurisdiction when the facility can effectively demonstrate to the Department's satisfaction, that the intent of the physical plant requirements are met and that the variation does not reduce the safety or operational effectiveness of the facility; and~~ The Division may grant an equivalency to allow alternate methods, procedures, design criteria or

functional variation from the requirements of this Rule and the rules contained in this Section. The equivalency may be granted by the Division when a governing body submits a written equivalency request to the Division that states the following:

(a) the rule citation and the rule requirement that will not be met due to strict conformance with current requirements would be impractical, extraordinary circumstances, new programs, or unusual conditions;

(b) the justification for the equivalency; and

(c) how the proposed equivalency meets the intent of the corresponding rule requirement.

(5) In determining whether to grant an equivalency request the Division shall consider whether the request will reduce the safety and operational effectiveness of the facility. The governing body shall maintain a copy of the approved equivalence issued by the Division.

(6) Where ~~rules or codes~~ rules, codes, or standards have any conflict, the more stringent requirement shall apply.

History Note: *Authority G.S. 131E-202;*
Eff. February 1, ~~1996.~~ 1996;
Readopted Eff. October 1, 2021.

10A NCAC 13D .2001 is proposed for amendment as follows:

SECTION .2000 – GENERAL INFORMATION

10A NCAC 13D .2001 DEFINITIONS

In addition to the definitions set forth in G.S. 131E-101, the following definitions shall apply throughout this Subchapter:

(1) "Abuse" means the willful infliction of injury, unreasonable confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish.

(2) "Accident" means an unplanned event resulting in the injury or wounding of a patient or other individual.

(3) "Addition" means an extension or increase in floor area or height of a building.

(4) "Administrator" as defined in G.S. 90-276(4).

(5) "Alteration" means any construction or renovation to an existing structure other than repair, maintenance, or addition.

(6) "Brain injury long term care" means an interdisciplinary, intensive maintenance program for patients who have incurred brain damage caused by external physical trauma and who have completed a primary course of rehabilitative treatment and have reached a point of no gain or progress for more than three consecutive months. Brain injury long term care is provided through a medically supervised interdisciplinary process and is directed toward maintaining the individual at the optimal level of physical, cognitive, and behavioral functions.

(7) "Capacity" means the maximum number of patient or resident beds for which the facility is licensed to maintain at any given time.

(8) "Combination facility" means a combination home as defined in G.S. 131E-101.

(9) "Comprehensive, inpatient rehabilitation program" means a program for the treatment of persons with functional limitations or chronic disabling conditions who have the potential to achieve a significant improvement in activities of daily living, including bathing, dressing, grooming, transferring, eating, and using speech, language, or other communication systems. A comprehensive, inpatient rehabilitation program utilizes a coordinated and integrated, interdisciplinary approach, directed by a physician, to assess patient needs and to provide treatment and evaluation of physical, psychosocial, and cognitive deficits.

(10) "Department" means the North Carolina Department of Health and Human Services.

(11) "Director of nursing" means a registered nurse who has authority and responsibility for all nursing services and nursing care.

(12) "Discharge" means a physical relocation of a patient to another health care setting; the discharge of a patient to his or her home; or the relocation of a patient from a nursing bed to an adult care home bed, or from an adult care home bed to a nursing bed.

(13) "Existing facility" means a facility currently ~~licensed, a proposed facility, a proposed addition to a licensed facility, or a proposed remodeled licensed facility that will be built according to design development drawings and specifications approved by the Department for compliance with the standards established in Sections .3100, .3200, and .3400 of this Subchapter,~~ licensed and built prior to the effective date of this Rule.

(14) "Facility" means a nursing facility or combination facility as defined in this Rule.

(15) "Incident" means any accident, event, or occurrence that is unplanned, or unusual, and has caused harm to a patient, or has the potential for harm.

(16) "Inpatient rehabilitation facility or unit" means a free-standing facility or a unit (unit pertains to contiguous dedicated beds and spaces) within an existing licensed health service facility approved in accordance with G.S. 131E, Article 9 to establish inpatient, rehabilitation beds and to provide a comprehensive, inpatient rehabilitation program.

(17) "Interdisciplinary" means an integrated process involving representatives from disciplines of the health care team.

(18) "Licensee" means the person, firm, partnership, association, corporation, or organization to whom a license to operate the facility has been issued. The licensee is the legal entity that is responsible for the operation of the business.

(19) "Medication error rate" means the measure of discrepancies between medication that was ordered for a patient by the health care provider and medication that is administered to the patient. The medication error rate is calculated by dividing the number of errors observed by the surveyor by the opportunities for error, multiplied times 100.

(20) "Misappropriation of property" means the deliberate misplacement, exploitation, or wrongful, temporary or permanent use of a patient's belongings or money without the patient's consent.

(21) "Neglect" means a failure to provide goods and services necessary to avoid physical harm, mental anguish, or mental illness.

(22) "New facility" means a ~~proposed facility,~~ facility for which an initial license is sought, a proposed addition to an existing facility, or a proposed remodeled portion of an existing facility that will be built according to ~~design development drawings~~ construction documents and specifications approved by the Department for compliance with the standards established in Sections .3100, .3200, and .3400 of this ~~Subchapter after the effective date of this Rule.~~ Subchapter.

(23) "Nurse Aide" means a person who is listed on the N.C. Nurse Aide Registry and provides nursing or nursing-related services to patients in a nursing home. A nurse aide is not a licensed health professional. Nursing homes that participate in Medicare or Medicaid shall comply with 42 CFR 483.35, which is incorporated by reference, including subsequent amendments. The Code of Federal Regulations may be accessed at https://www.ecfr.gov.

(24) "Nursing facility" means a nursing home as defined in G.S. 131E-101.

(25) "Patient" means any person admitted for nursing care.

(26) "Remodeling" means alterations, renovations, rehabilitation work, repairs to structural systems, and replacement of building systems at a nursing or combination facility.

(27) "Repair" means reconstruction or renewal of any part of an existing building for the purpose of its maintenance.

(28) "Resident" means any person admitted for care to an adult care home part of a combination facility.

(29) "Respite care" means services provided for a patient on a temporary basis, not to exceed 30 days.

(30) "Surveyor" means a representative of the Department who inspects nursing facilities and combination facilities to determine compliance with rules, laws, and regulations as set forth in G.S. 131E-117; Subchapters 13D and 13F of this Chapter; and 42 CFR Part 483, Requirements for States and Long Term Care Facilities.

(31) "Violation" means a failure to comply with rules, laws, and regulations as set forth in G.S. 131E-117 and 131D–21; Subchapters 13D and 13F of this Chapter; or 42 CFR Part 483, Requirements for States and Long Term Care Facilities, that relates to a patient's or resident's health, safety, or welfare, or that creates a risk that death, or physical harm may occur.

History Note: *Authority G.S. 131E-104;*
RRC objection due to lack of statutory authority Eff. July 13, 1995;
Eff. January 1, 1996;
Readopted Eff. July 1, 2016;
Amended Eff. October 1, 2021; January 1, 2021.

NC MCC Bond Sale Approval Form	
Facility Name: Vidant Health	
	Time of Preliminary Approval
SERIES: 2021A	
PAR Amount	$123,780,000.00
Estimated Interest Rate [1]	1.89%
All-in True Interest Cost	1.73%
Maturity Schedule (Interest) - Date	Monthly, 4/1/2021 - 6/1/2033
Maturity Schedule (Principal) - Date	Annually, 6/1/2021 - 6/1/2033
Bank Holding Period (if applicable) - Date	6/1/2033 (to maturity)
Estimated NPV Savings ($) (if refunded bonds)	$10,746,689
Estimated NPV Savings (%) (if refunded bonds)	10.50%
NOTES:	
1. Estimated interest rate is represented by taxable rate on the Cinderella Bonds	
	Time of Preliminary Approval
SERIES: 2025A	
PAR Amount	$117,520,000.00
Estimated Interest Rate [1]	1.49%
All-in True Interest Cost	1.73%
Maturity Schedule (Interest) - Date	Monthly, 4/1/2025 - 6/1/2033
Maturity Schedule (Principal) - Date	Annually, 6/1/2025 - 6/1/2033
Bank Holding Period (if applicable) - Date	6/1/2033 (to maturity)
Estimated NPV Savings ($) (if refunded bonds)	$10,746,689
Estimated NPV Savings (%) (if refunded bonds)	10.50%
NOTES:	
1. Estimated interest rate is represented by tax-exempt rate on the Cinderella Bonds	

EXHIBIT H

THE FOREST AT DUKE

SCHEDULE OF FEES

Single Occupancy		Square Footage	Amortized Entry Fee	Monthly Service Fee
APARTMENTS				
Ash	1BDR	553	$ 97,970	$3,332
Beech	1BDR Expanded	717	131,676	3,861
Cedar	1 BDR with Den	914	191,417	4,370
Dogwood	2 BDR	1144	251,419	4,969
Elm	2 BDR with Den	1243	268,891	5,332
COTTAGES				
Alder	1BDR with Den	1207	286,035	5,062
Birch	2 BDR	1445	338,127	5,332
Chestnut	2 BDR with Den	1662	387,825	5,615
Pine	2 BDR with Study	2200	536,974	5,805
Holly	2 BDR with Study	2362	559,938	5,991
Magnolia	2 BDR with Study	2558	582,891	6,115

Double Occupancy				
APARTMENTS				
Ash	1 BDR	553	$ 130,970	$5,039
Beech	1 BDR Expanded	717	164,676	5,568
Cedar	1 BDR with Den	914	224,417	6.077
Dogwood	2 BDR	1144	284,419	6,676
Elm	2 BDR with Den	1243	301,891	7,039
COTTAGES				
Alder	1 BDR with Den	1207	319,035	6,769
Birch	2 BDR	1445	371,127	7,039
Chestnut	2 BDR with Den	1662	420,825	7,322
Pine	2 BDR with Study	2200	569,974	7,447
Holly	2 BDR with Study	2362	592,938	7,633
Magnolia	2 BDR with Study	2558	615,891	7,757

Effective October 1, 2020.

NC MCC Bond Sale Approval Form		
Facility Name:		
	Time of Preliminary Approval	
SERIES:		
PAR Amount	$57,575,000.00	
Estimated Interest Rate	3.28%	
All-in True Interest Cost	3.35%	
Maturity Schedule (Interest) - Date	9/1/2021 - 9/1/2051	
Maturity Schedule (Principal) - Date	9/1/2030 - 9/1/2051	
Bank Holding Period (if applicable) - Date	N/A	
Estimated NPV Savings ($) (if refunded bonds)	N/A	
Estimated NPV Savings (%) (if refunded bonds)	N/A	
NOTES:		
- Interest rate assumption assumes The Forest at Duke is rated BBB+ for the proposed financing.		

EXHIBIT I

North Carolina Medical Care Commission Meeting

The Forest at Duke, Inc.

Friday, February 12, 2021

THE FOREST AT DUKE

Overview

- A long-standing, non-profit continuing care retirement community located in Durham, NC on 47-acre campus adjacent to Duke University
- In operation since 1992; currently about 400 residents and 275 employees
- Campus currently includes: 154 apartments, 95 cottages, 34 adult care (assisted living) beds and 58 nursing beds
- Contracts are “Life Care” agreements – which means residents pay an entry fee and an ongoing monthly service fee (which covers virtually all living expenses regardless of level of care/residence)
- Governed by an 15-member, self-perpetuating Board of Directors
- Fully stable and operating near full occupancy in recent years
- Currently rated “A” (stable outlook) by Fitch; accredited by CARF-CCAC since 2007 (renewed in 2017)
- CMS 5-Star Rating

Mission & Values

Our mission is to provide a caring, responsible community that fosters the independence of residents of retirement age by enhancing their capability to lead purposeful, active, healthy and secure lives.

We are dedicated to:

- A high quality of community life.
- A pursuit of everyday excellence.
- Respect and support for each person.
- Accountability and integrity in all we do.
- Purposeful community responsibility.

Our Team

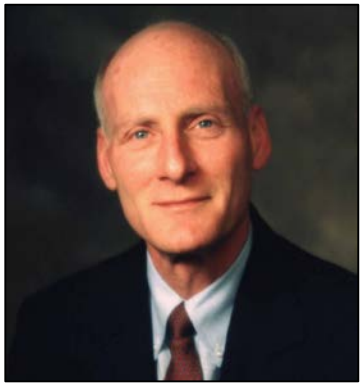
Anita Holt
President/CEO

Sharon Pitt
Chief Operating Officer

Karen Henry
Chief Financial Officer

Lee Ann Bailey-Clayton
Director of Health Services

Alice Sharpe
Board Chair



Harvey Cohen
Vice Board Chair

Michelle Harper
Board Treasurer

Ken Gibbs
Executive Committee

Diversity

- We believe our governing board and leadership teams should be reflective of our community and the community of those we seek to serve
- Board Makeup
  - Since 1999, 25% of the board has been African-American, on average
  - FY 21 Board has 15 members: 6 are women, 3 are African-American
  - Current board chair is an African-American woman
- Management
  - 7 of 8 members of leadership team are women
  - Both CEO and COO are African-American women
  - Broader 21-person leadership team includes 13 African-Americans
- Residents
  - Current resident population 70% female, 30% male
  - 5% of residents include: African-American, Asian, Indian, German, Russian or Israeli backgrounds

SOCIAL ACCOUNTABILITY

We are committed to approximately $1.5 million (5%) of annual revenue, comprised of the following:

- Charitable care and benevolence
- Residency scholarship
- Volunteer and community service
- Community partnerships and grants
- In-kind provision of space and services for community non-profits

Our focus has been to support those in the community who serve those who are most vulnerable and at risk, which includes:

- Children and families
- Food insecurity
- Homelessness
- At-risk seniors
- Health care advocacy

Campus Site Plan (Aerial Photo)

Source: Management Photo

Campus Photos

Apartment Interior

Apartment Interior

Cottage Exterior

Cottage Interior

Source: Management

Campus Photos

Dining Stations

Dining Room

Library

Swimming Pool

Source: Management

Historical Occupancy & Financial Performance

Historical Occupancy

FYE, September 30th	2018	2019	2020	2021 YTD (1)
Independent Living Units	95%	93%	96%	93%
Assisted Living Units	82%	88%	71%	59%
Skilled Nursing Units	91%	88%	86%	76%

(1) As of December 31, 2020. Note: one eight-unit AL neighborhood was vacated to serve as a COVID unit. Fortunately, no positive tests or deaths have occurred at this time.

Historical Financial Ratios

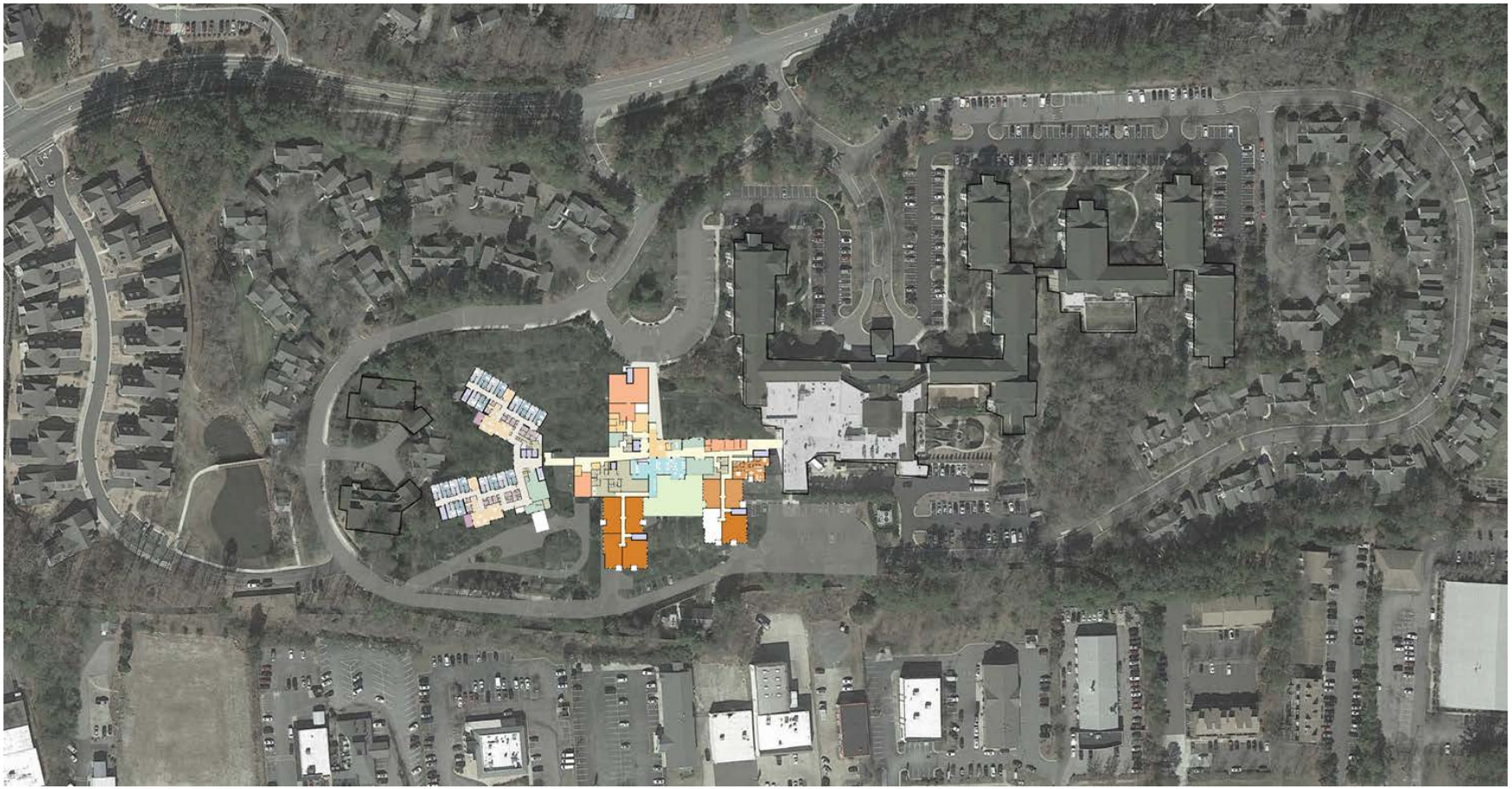
FYE, September 30th	2018	2019	2020
Debt Service Coverage Ratio	4.49x	5.01x	3.51x
Days' Cash on Hand	613 Days	670 Days	692 Days

Source: Management

Overview of Project

- Current healthcare center includes 92 licensed beds (58 nursing beds and 34 adult care (assisted living) beds)
- Planned project is replacement of the current facility with 90 new units in a so-called “small house” format
- “Small house” format is a contemporary model of care designed around houses (groups of rooms) in which each house has 10 rooms, each room with a bathroom, and all commons spaces and support areas located within the house. A very personalized approach to living and care where residents have significant say over their day to day activities
- Building proposed as five-story, 110,000 square foot structure
- Significant planning has taken place in recent years to identify, validate and advance the project, its costs and the operational outcomes, and the corresponding culture-change in terms how such care will be delivered

Site Plan Including New Construction



I-12

Source: Architect's Rendering

New Healthcare Center

I-13

Source: Architect's Rendering

New Healthcare Center

I-14

Source: Architect’s Rendering

Sample Small House Layout

Development Team

Development Advisor:	NEMA Management
Architect :	Perkins Eastman
Contractor:	Whiting Turner
Financial Feasibility:	Clifton Larson Allen
Auditor:	Clifton Larson Allen
Investment Banker:	Ziegler
Bond Counsel:	Robinson Bradshaw Hinson
Corporate Counsel:	Womble Bond Dickinson
Underwriter's Counsel:	Parker Poe
Trustee:	US Bank

Source: Management

Proposed Financing: Sources & Uses of Funds

- Series 2021 Financing Objectives:
  - Fund costs of new (replacement) 90-unit nursing/healthcare building;
  - Fund debt service reserve fund and funded interest;
  - Pay a portion of the costs of issuance associated with the financing; and,
  - Bank RFP process will be conducted in February & March.

Sources of Funds*		Uses of Funds*	
2021 – Publicly Offered Bonds	$57,575,000	Project Fund	$44,705,000
		Debt Service Reserve Fund	5,146,000
		Funded Interest	6,523,000
		Costs of Issuance	1,201,000
Total Sources of Funds	**$57,575,000**	**Total Uses of Funds**	**$57,575,000**

* Preliminary, subject to change.

- Depending on results of bank RFP, a direct bank placement structure may be used, which could reduce or eliminate the need for funded interest and/or a debt service reserve fund.

Source: Management

Preliminary Projected Financial Performance

- Management has engaged NEMA Management for development advisory work and Clifton Larson Allen (“CLA”) as auditor and feasibility consultant.

- The key preliminary projected financial ratios are summarized below:

FYE September 30,	2021	2022	2023	2024	2025
Debt Service Coverage	5.20x	1.53x	1.56x	1.62x	1.65x
Days’ Cash on Hand	711 Days	597 Days	573 Days	566 Days	560 Days

- The bond sizing for the financial forecast was run at an interest rate assumption of 6.00%.

Source: Management

Timeline & Next Steps*

- February 12, 2021 - Preliminary MCC Approval
- May 2021 - LGC Approval Meeting
- May 2021 - Mail POS
- May 2021 - Price Bonds
- May 2021 - Close
- December 2022 - Construction Conclusion

*Preliminary, subject to change.

QUESTIONS & DISCUSSION