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To: Members, Arkansas State Board of Health

From: Paula Day, Section Chief
Health Systems Licensing and Regulation
Division for Health Protection

Date: October 11, 2025

Subject: To request approval by the State Board of Health of the following proposed amendments to the Rules for Hospice Agencies in Arkansas.

Authority: Ark. Code § 20-10-801, et seq.

Relevant Acts: Acts 141 and 591 of 2025

20 CAR § 47-103. Definitions

- Change name for additional hospice location for a primary location from “satellite office” or “alternate delivery site” to “Multiple location” to utilize same terminology as CMS. There is not a state statute for this term. (page 4)

20 CAR § 47-118. Clinical Records

- Act 141 – Added allowance of electronic medical records (page 23)

20 CAR § 47-124. Physical facilities

- Act 591 – allows private professional providers to complete building project review and approval. (page 40)

20 CAR § 47-132. Multiple location

- Change name for additional hospice location for a primary location from “satellite office” or “alternate delivery site” to “Multiple location” to utilize same terminology as CMS. There is not a state statute for this term. (page 61)

Arkansas Department of Health
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Proposed Rulemaking

Title Rules for Hospice in Arkansas

Promulgated by:
Department of Health

Title 20. Public Health and Welfare

Chapter I. Generally, Department of Health

Subchapter B. Health Facilities

Part 47. Rules for Hospice in Arkansas

Subpart 1. Generally

20 CAR § 47-101. Preface.

(a)(1) This part has been prepared for the purpose of establishing criteria for minimum standards for the licensure, operation, and maintenance of hospices in Arkansas that are consistent with current trends in patient care practices.

(2) By necessity they are of a regulatory nature, but are considered to be practical minimal design and operational standards for these facilities.

(3) These standards are:

(A) Not static; and

(B) Subject to periodic revisions in the future as new knowledge and changes in patient care trends become apparent.

(b) However, it is expected that facilities:

(1) Will exceed these minimum requirements; and

(2) Will not be dependent upon future revisions in these standards as a necessary prerequisite for improved services.

(c) Hospices have a strong moral responsibility for providing optimum patient care and treatment for the terminally ill and their families.

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20 CAR § 47-102. Purpose.

(a) To establish rules for minimum standards for hospice programs operating in the State of Arkansas.

(b) This part:

(1) Will ensure high quality professional care for terminally ill patients and their families by providing for the safe, humane, and appropriate palliative care of all admitted to the hospice program regardless of setting; and

(2) Shall apply to both new and existing agencies.

20 CAR § 47-103. Definitions.

(a) The word "shall" as used in this part means mandatory.

(b) As used in this part:

(1) "Administrator" means the person responsible for the management of a hospice;

(2) "Attending physician" means a doctor of medicine or osteopathy who is:

(A) Licensed in the State of Arkansas; and

(B) Identified by the patient, at the time he or she elects to receive hospice care, as having the most significant role in the determination and delivery of the patient's medical care;

(3) "Autonomous" means a separate and distinct entity that functions under its own administrations and bylaws either within or independently of a parent organization;

(4) "Bereavement counseling" means counseling services provided to the patient's family after the patient's death;

(5) "Clergy" or "pastoral counselor" means an individual with training in spiritual counseling;

(6) "Department" means the Department of Health;

(7) "Division of Health Facilities Services" is the facility licensing division of the Department of Health;

(8) "Election statement" means the initial election for hospice care signed by the patient or patient's representative;

(9)(A) "Employee" means an individual paid either through a salary or on an hourly or per-visit basis and a Form W-2 is issued on his or her behalf.

(B) An "employee" also refers to a volunteer under the jurisdiction of the hospice;

(10) "Functional program" describes those services to be provided by the hospice for the operation of the facility;

(11) "Hospice agency" means any agency, person, partnership, association, corporation, or other organization, whether public or private, proprietary or nonprofit, that provides hospice service;

(12) "Hospice" or "hospice care" means an autonomous, centrally administered, medically directed, coordinated program providing a continuum of home, outpatient, and homelike inpatient care for the terminally ill patient and family, employing an interdisciplinary team to assist in providing palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social, and economic stresses that are experienced during the final stages of illness and during dying and bereavement, with such care:

(A) Being available twenty-four (24) hours a day, seven (7) days a week; and

(B) Provided on the basis of need regardless of ability to pay;

(13) "Informed consent" specifies the type of care and services agreed upon by the hospice patient or the patient's representative;

(14) "Inpatient direct care hospice" means a licensed hospice facility that provides direct inpatient care to the terminally ill;

(15) "Multiple location means an approved location or site from which a hospice provides services within a portion of the total geographic area served by the parent hospice agency;

~~(1516)~~ "Registered nurse" (RN) means a person licensed in the State of Arkansas as a registered nurse;

(1617) "Representative" means a person who is, because of the patient's mental or physical incapacity, authorized in accordance with state law to execute or revoke an election for hospice care or terminate medical care on behalf of the terminally ill patient;

~~—(17) "Satellite office" or "alternate delivery site" means an approved location or site from which a hospice provides services within a portion of the total geographic area served by the parent hospice agency;~~

(18) "Service area" means the geographic land area for which the agency shall be licensed consistent with the agency's permit of approval (POA) or the service area of record prior to the requirement for a POA;

(19) "Social worker" means a person who:

(A) Has at least a bachelor's degree from a school accredited or approved by the Council on Social Work Education; and

(B) Is licensed by the State of Arkansas as a social worker; and

(20) "Terminally ill" means that the patient:

(A) Is in the last phases of an incurable illness or condition; and

(B) Has a limited prognosis.

20 CAR § 47-104. Requirements and codes.

(a)(1) All agencies providing hospice services in the home shall comply with 20 CAR §§ 47-101 – 47-120.

(2) Inpatient direct care hospices shall comply with 20 CAR §§ 47-101 – 47-132.

(b) Licensure.

(1) No public or private agency or person shall establish, conduct, or maintain a hospice or hold itself out to the public as a hospice without first obtaining licensure from the Department of Health.

(2)(A) Licensure to operate a hospice issued by the department shall be based upon the results of an operational and physical plant survey conducted by the department to determine compliance with this part.

(B) Licensure for the operation of a hospice program shall, unless sooner revoked, be for a period of one (1) year.

(c) **Revocation.**

(1) The department may deny, suspend, or revoke a license on any of the following grounds:

(A) Violation of this part; or

(B) Permitting, aiding, or abetting the commission of any unlawful act in connection with the operation of a hospice.

(2) Revocation shall be effective for a minimum of ninety (90) days before the department accepts reapplication.

(3) Right of appeal shall be through the State Board of Health.

(d) **Application.**

(1)(A) An applicant shall file applications under oath with the department upon forms prescribed by the department.

(B) The application shall be signed:

(i) By the owner;

(ii) If a partnership or corporation, by two (2) of its officers; and

(iii) In the case of a governmental unit, by the head of the governmental unit having jurisdiction.

(2) The application shall set forth:

(A) The full name and address of the hospice for which state licensure is sought; and

(B) Such additional information as the department may require.

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

(e) **Change of ownership.**

(1) The hospice shall notify the Division of Health Facilities Services in writing at least thirty (30) days prior to the effective date of change of ownership.

(2) The following information shall be submitted:

(A) License application;

- (B) Request for Medicare certification, where applicable;
- (C) Legal documents, ownership agreements, the license previously issued to the hospice, and other information to support relicensure requirements; and
- (D) Licensure fee.

(f) **Name/address change.**

(1) The hospice shall notify the division in writing of any name, ~~and/or~~ address change, or both.

(2) The following information shall be submitted:

- (A) The new address;
- (B) The previously issued license shall be returned to the division; and
- (C) Appropriate fee.

(g) **Management contract.**

(1) The licensed hospice shall notify the division in writing at least thirty (30) days prior to entering into a contract for overall management of the hospice.

(2) A copy of the contract shall be submitted to the division.

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

20 CAR § 47-105. Governing body.

(a) The hospice shall have a governing body that assumes full legal responsibility for determining, implementing, and monitoring policies governing the hospice's total operation.

(b) The governing body shall designate an individual who is responsible for the day-to-day management of the hospice program.

(c) The governing body shall designate a medical director who assumes overall responsibility for the medical component of patient care.

(d) The governing body's records shall reflect direct involvement in hospice policy development and oversight to include but not be limited to:

- (1) Responsibilities of the administrator and medical director;

(2) Management of contracted services;
(3) Patient admission criteria;
(4) Patient and family involvement in patient care planning; and
(5) An ongoing, comprehensive self-assessment of the quality of care provided to patients.

(e) There shall be a schedule of not less than quarterly meetings during each calendar year and minutes shall be maintained of the meetings.

(f) The governing body shall ensure:

(1) Nursing services, physician services, drugs, and biologicals are routinely available on a twenty-four-hour basis;

(2) All other services are available on a twenty-four-hour basis to the extent necessary to meet the needs of patients for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions; and

(3) All services provided are consistent with accepted standards of practice.

20 CAR § 47-106. Patient rights and responsibilities.

(a) A hospice shall inform and document that each patient, or when appropriate the patient's representative, has been informed of the following before or during the initial evaluation:

(1)(A) The right to:

(i) Appropriate and professional quality services regardless of:

(a) Race;

(b) Creed;

(c) Color;

(d) Religion;

(e) Sex;

(f) National origin;

(g) Sexual preference;

(h) Disability; or

(i) Age; and

(ii) Be free from physical abuse, mental abuse, and/or neglect.

(B) The patient and property shall be treated with dignity and respect by all that provide services;

(2) The right to receive an explanation of the informed consent and election statement that is signed by the patient or patient's representative for the provision of hospice care;

(3) The right to participate in the decision-making process regarding:

(A) Where care is to be delivered; and

(B) The options available;

(4) The right to receive a timely response from the hospice agency regarding any request for services;

(5) The right to privacy and confidentiality;

(6) The right to be informed of:

(A) The name of the hospice agency;

(B) Services offered by the agency;

(C) Services being provided to the patient; and

(D) How to contact that agency during all hours;

(7) The right to be informed of the:

(A) Process of submitting and addressing complaints to the hospice agency; and

(B) Address and phone number of the state licensing agency;

(8) The right to be informed that a hospice may not discontinue or diminish care because of the lack of a payor source;

(9) The right to be informed orally and in writing, prior to service, of expected payment sources, i.e., Medicare, Medicaid, and various other payor; and

(10) Services the hospice does not cover.

(b) The agency shall provide each patient and patient's representative with a list affirming the patient's and patient's representative's responsibility to:

(1) Assist in developing and maintaining a safe environment, when possible;

(2) Treat all agency staff with respect;

- (3) Participate in the development and update of the plan of care; and
- (4) Adhere to the plan of care as developed by the agency and assist in the care as necessary.

20 CAR § 47-107. Administration.

(a) Administration shall provide and document the following:

- (1) Job descriptions for all employees and volunteers;
- (2) Policies and procedures for each available service;
- (3) In-services pertinent to hospice care shall be ongoing for:
 - (A) Employees;
 - (B) Volunteers; and
 - (C) Contracted staff;
- (4) Orientation for all:
 - (A) Employees;
 - (B) Volunteers; and
 - (C) Contracted staff;
- (5) Annual review of policies and procedures; and
- (6) Criminal history checks for employees and volunteers as required by

Arkansas Code § 20-38-101 et seq.

(b) Services by arrangement.

(1) A hospice may arrange for another individual or entity to furnish services to the patients.

(2) If services are provided under arrangement (i.e., under contract), the following standards shall be met:

- (A)(i) Continuity of care.
 - (ii) The hospice program shall ensure the continuity of patient/family care in home, outpatient, and inpatient settings; and
- (B)(i) Written agreement.
 - (ii) The hospice shall have a written agreement for the provision of contracted services.

(iii) The contract shall include at least the following:

(a) Identification of services to be provided; and

(b) Qualifications of personnel providing the services.

(c) **Short-term inpatient care.** The hospice shall have a written agreement approved with an area hospital, hospice inpatient facility, or qualified skilled nursing facility that states that the hospice may continue to follow any hospice patient admitted to that facility.

(d) **Continuation of care.** A hospice may not discontinue or diminish care because of the lack of a payor source.

(e) **Licensure.** The hospice and all hospice employees shall be licensed in accordance with applicable federal, state, and local laws.

(f) **Core services.**

(1) A hospice shall ensure all core services (i.e., nursing, medical social services, and counseling) described in the following section are routinely provided directly by hospice employees.

(2) A hospice may use contracted staff if necessary to supplement hospice employees in order to meet the needs of patients:

(A) During periods of peak patient loads; or

(B) Under extraordinary circumstances.

(3) If contracting is used, the hospice shall:

(A) Maintain professional, financial, and administrative responsibility for the services; and

(B) Ensure the qualifications of staff and services provided meet the requirements specified for:

(i) Nursing;

(ii) Medical social services;

(iii) Physician services; and

(iv) Counseling.

(4) **Note.**

(A) Physician services may be provided by an individual contract.

(B) The contract must specify the physician will assume all responsibilities as outlined in 20 CAR § 47-110.

(g) **Postmortem procedures.** The hospice agency shall have a procedure addressing postmortem procedures.

(h) **Pet therapy.**

(1) Pet therapy may be provided by the hospice in the patient's home.
(2) Birds, cats, dogs, and other animals may be permitted in the patient's home.

(3) Therapy animals shall have appropriate vaccinations and licenses.

(4) A veterinary record:

(A) Shall be kept on all therapy animals to:

(i) Verify vaccinations; and

(ii) Be made readily available for review; and

(B) Shall not negatively affect the well-being of the patient.

(i) **Employee health.**

(1) It shall be the responsibility of administration, with advice and guidance from the medical staff and the Infection Control Committee, to establish and enforce policies concerning preemployment physicals and employee health.

(2) The policies shall include but are not limited to:

(A) Requirements for an up-to-date health file for each employee;

(B)(i) There shall be measures for prevention of communicable disease outbreaks, especially *Mycobacterium tuberculosis* (TB).

(ii) All plans for preventing the transmission of TB shall conform to the most current Centers for Disease Control and Prevention Guidelines for Preventing the Transmission of *Mycobacterium tuberculosis* in Healthcare Settings; and

(C)(i) Work restrictions shall be placed on personnel who are known to be affected with any disease in a communicable stage.

(ii) Such individuals shall not work in any area in any capacity in which there is:

(a) The likelihood of transmitting disease to patients, personnel, or other individuals within the hospice; or

(b) A potential of contaminating food, food contact surfaces, supplies, or any surface with pathogenic organisms.

(j) **Complaints.**

(1) Each agency shall keep a record of complaints received.

(2) Documentation shall include the:

(A) Name of the complainant;

(B) Relationship to the patient;

(C) Nature of the complaint; and

(D) Action taken to resolve the complaint.

(k) **Informed consent.** An informed consent shall be signed by the patient or patient's representative for provision of hospice care.

(l) **Certification of terminal illness.** The agency shall have certification signed by the attending physician and medical director or physician designee stating the patient has a terminal illness.

(m) **Election of hospice care.**

(1) **Duration of election.** An election to receive hospice care shall be considered to continue as long as the patient remains:

(A) In the care of a hospice or does not revoke the election for hospice care; and

(B) Certified as appropriate for hospice.

(2) **Effective date of election.** A patient or patient's representative may designate an effective date for the election period that begins with the first day of hospice care.

(3) **Waiver of other benefits.** A patient or patient's representative can elect hospice care from only one (1) hospice provider at any given time.

(n) **Elements of the election statement.** The election statement shall include the following:

(1) Identification of the hospice that provides care to the patient;

(2) The patient's or the patient's representative's acknowledgment that he or she has been given a full understanding of the palliative rather than curative nature of hospice care as it relates to the patient's terminal illness;

(3) The effective date of the election; and

(4) The signature of the patient or patient's representative.

(o) Revoking the election of hospice care.

(1) A patient or patient's representative may revoke the patient's election of hospice care at any time during an election period.

(2) To revoke the election of hospice care, the patient or patient's representative shall file a statement with the hospice that includes the following information:

(A) A signed statement that the patient or patient's representative revokes the patient's election for hospice care; and

(B)(i) The date the revocation is effective.

(ii) A patient or patient's representative may not designate an effective date earlier than the date that the revocation is made.

(p) A written notice of the felony status under Arkansas Code § 5-13-202 of attacking a healthcare worker shall be posted in all public entrances and patient waiting area of the healthcare facility utilizing the digital poster available on the Department of Health website.

(q) A healthcare provider shall not mislead any patient regarding the healthcare provider's licensure status.

20 CAR § 47-108. Quality improvement (QI).

(a)(1) The organization shall develop, implement, and maintain an ongoing program to assess and improve the quality of care and services provided.

(2) A quality improvement (QI) plan shall be developed and maintained to describe the manner in which QI activities shall be conducted.

(3) The QI plan shall be reviewed and approved by the medical staff and governing body annually.

(4) All hospice programs, services, departments, and functions, including contracted services related to patient care, shall participate in ongoing quality improvement activities.

(5) The hospice shall collect and assess data on the functional activities identified as priorities in the QI plan.

(6) Improvement strategies shall be developed for programs, services, departments, and functions identified with opportunities for improvement.

(7) The effectiveness of improvement strategies and actions taken shall be monitored and evaluated, with documentation of conclusions regarding effectiveness.

(b) The QI program shall include but not be limited to ongoing assessment and improvement activities regarding the following:

(1) Access to care, processes of care, outcomes of care, and hospice-specific clinical data; and

(2) Customer satisfaction (patients and families, physicians, and employees).

20 CAR § 47-109. Infection control.

(a) Each hospice shall develop an infection control program that protects patients, family, and personnel from nosocomial or community-acquired infections.

(b) The hospice shall develop and use a coordinated process that effectively reduces the risk of endemic and epidemic nosocomial infections in:

(1) Patients;

(2) Healthcare workers; and

(3) Visitors.

(c) It shall be the duty of the administrator or his or her designee to report all known infectious or communicable diseases as required by Arkansas Code § 20-7-109 to the Department of Health's Arkansas Center for Health Statistics.

(d) There shall be policies and procedures establishing and defining a comprehensive infection control program to include:

(1) Provisions for education on universal precautions to patients, families, and hospice employees, including but not limited to:

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(A) Hand hygiene, including procedures for soap and water as well as alcohol-based hand rub if used;

(B) Disinfections;

(C) Liquid and solid waste disposal of infectious waste;

(D) Needle disposal; and

(E) Other means of limiting the spread of contagion; and

(2) A plan for monitoring and evaluating all aseptic and sanitation techniques employed in the hospice to ensure that approved infection control procedures are followed.

(e) There shall be an orientation program for all new healthcare workers concerning:

(1) The importance of infection control; and

(2) Each healthcare worker's responsibility in the infection control program.

(f) There shall be a plan for each employee to receive annual in-services and educational programs as indicated based on assessments of the infection control process.

(g) No items shall be used past the expiration date.

(h) One-time patient care items shall not be reused.

20 CAR § 47-110. Physician services.

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

(1) Ensuring and maintaining quality standards of medical practice;

(2) Achievement and maintenance of quality assurance of medical practices through a mechanism for the assessment of patient/family care outcomes;

(3) Certification of terminally ill patients admitted to the hospice program;

(4) Participation as a member of the interdisciplinary team in the development, implementation, and assessment of the patient/family plan of care; and

(5) Consulting with the attending physician regarding patient care plans.

(b) Physician services.

- (1) Physician services shall be provided in accordance with hospice policies.
- (2) Such policies shall include provisions governing the relationship of the staff physicians, attending physician, and the medical director to:
 - (A) Each other; and
 - (B) The interdisciplinary team.
- (3) In addition to palliation and management of the terminal illness and related conditions, physician employees of the hospice, including the physician member or members of the interdisciplinary group, must also meet the general medical needs of the patients to the extent that these needs are not met by the attending physician.

20 CAR § 47-111. Nursing services.

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

20 CAR § 47-112. Interdisciplinary group.

- (a) The interdisciplinary group or groups shall be composed of individuals who provide or supervise the care and services offered by the hospice.
- (b) **Composition of the interdisciplinary group.** The interdisciplinary group or groups shall include at least the following individuals:
 - (1) A doctor of medicine or osteopathy;
 - (2) A registered nurse;
 - (3) A social worker; and
 - (4) A pastoral or other counselor.
- (c) **Role of the interdisciplinary group.** The interdisciplinary group shall:
 - (1) Participate in the establishment of the plan of care;
 - (2) Provide supervision of hospice care and services; and

(3) Periodically review and update the plan of care to reflect the needs of each patient receiving hospice care.

20 CAR § 47-113. Volunteers.

(a)(1) The hospice shall use volunteers in defined roles under the supervision of a designated hospice employee.

(2) The hospice shall maintain documentation of active and ongoing efforts to recruit and retain volunteers.

(b) **Training.** Orientation and training shall be provided consistent with acceptable standards of hospice practice.

(c) **Role.** Volunteers may be used in administrative services or direct patient care.

(d) **Level of activity.**

(1) A hospice shall maintain a volunteer staff sufficient to provide administrative or direct patient care at a minimum that equals five percent (5%) of the total patient care hours of all paid hospice employees and contract staff.

(2) The hospice shall maintain a continuing level of volunteer activity.

(3) Expansion of care and services achieved through the use of volunteers, including the type of services and the time worked, shall be recorded.

(e) **Employees as volunteers.** Hospice employees may be used as volunteers only after completing a hospice volunteer training program.

20 CAR § 47-114. Counseling services.

Counseling services shall:

(1) Be available to the patient and the family; and

(2) Include the following:

(A)(i) Bereavement services.

(ii) There shall be an organized program for provision of bereavement services under the supervision of an individual with specialized bereavement training.

(iii) The plan of care for these services shall reflect family needs that shall include personal visits up to one (1) year following the patient's death.

(iv) Refusal or variations from the visits or contacts shall be documented;

(B)(i) Dietary counseling.

(ii) A qualified dietitian shall provide dietary counseling when required;

(C)(i) Spiritual counseling.

(ii) The hospice shall notify the patient of the opportunity for spiritual counseling either from the hospice pastoral counselor or clergy of the patient's choice.

(iii) If the patient elects to have his or her clergy visit, the hospice shall make reasonable efforts to arrange for the visit or visits; and

(D)(i) Social services.

(ii) Social services shall be provided by a qualified social worker.

20 CAR § 47-115. Other services.

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

- (1) Physical therapy;
- (2) Occupational therapy; and
- (3) Speech-language pathology.

20 CAR § 47-116. Hospice aide and homemaker services.

(a)(1) Hospice aide services shall be available and adequate in frequency to meet the needs of the patient.

(2) A hospice aide is a person who meets at least one (1) of the following requirements:

(A)(i) Has at least one (1) year of experience in an institutional setting (home health agency, hospital, hospice, or long-term care facility).

(ii) This experience shall be verified by a previous employer;

(B)(i) Has a certificate issued by the State of Arkansas for work in long-term care facilities.

(ii) A copy of this certificate shall be available for review; or

(C)(i) Has completed a forty-hour aide training course that meets requirements set forth in this part.

(ii) In lieu of the requirement for completion of the hospice aide training course, a nursing student may qualify as a hospice aide by submitting documentation from the director of programs and/or the dean of a school of nursing that reflects the nursing student has demonstrated competency in providing basic nursing care in accordance with the school's curriculum.

(b)(1) Any aide who has not been employed as an aide in an institutional setting in the last twenty-four (24) months shall be observed by a registered nurse performing the skills required to care for a patient including:

- (A) Bathing;
- (B) Transferring;
- (C) Range of motion exercises;
- (D) Toileting;
- (E) Dressing;
- (F) Nail care; and
- (G) Skin care.

(2) The registered nurse shall observe the aide performing these skills on a person.

(3) Any other tasks or duties for which the aide may be responsible shall be evaluated by:

- (A) Written test;
- (B) Oral test; or
- (C) Observation.

(4) There shall be documentation by the agency to show evidence of this evaluation.

(c)(1) A registered nurse shall complete an aide assignment sheet for each patient receiving aide services.

(2) Each aide caring for the patient shall:

(A) Receive a copy of the assignment sheet; and

(B) Provide services as assigned.

(3) A copy of the assignment sheet shall be left in the patient's:

(A) Home; and

(B) Medical record.

(d) Each aide assignment sheet shall be individualized and specific according to the patient's needs.

(e) The registered nurse shall conduct a visit to the patient's place of residence at least every two (2) weeks to:

(1) Supervise the aide; and

(2) Update the aide assignment sheet.

(f)(1) In no event shall a hospice aide receive or write verbal orders from a physician.

(2) A hospice aide shall not perform any:

(A) Sterile procedure; or

(B) Procedure requiring the application of medication requiring a prescription.

(g)(1) Upon a request by a patient and/or family member for assistance with medications, the registered nurse may assign a hospice aide to assist with oral medications that are normally self-administered.

(2) Assistance shall be limited to:

(A) Reminding a patient to take a medication at a prescribed time;

(B) Opening and closing a medication container; and

(C) Returning a medication to a proper storage area.

(h) Except as otherwise provided in this part, duties of the hospice aide may include:

(1)(A) Personal care.

(B) **Example.** Bathing, grooming, feeding, ambulation, exercise, oral hygiene, and skin care, etc.;

(2) Assistance with medications ordinarily self-administered as assigned;

(3) Household services essential to health care in the home;

(4) Completion of records and reporting to appropriate supervisor;

(5) Taking and charting vital signs;

(6) Extension of therapy services; and

(7) Any duty consistent with the Arkansas State Board of Nursing Rules, 17 CAR pt. 120, on delegation of duties may be assigned by a registered nurse to meet the needs of the patient.

(i)(1) If the training is provided by the agency, the training program for hospice aides shall be conducted under the supervision of a registered nurse.

(2) The training program may contain other aspects of learning, but shall include the following:

(A) A minimum of forty (40) hours of classroom and clinical instruction related particularly to the hospice setting;

(B) Written course objectives with expected outcomes and methods of evaluation;

(C) An assessment that the student knows how to:

(i) Read;

(ii) Write; and

(iii) Carry out directions; and

(D) Orientation to:

(i) Hospice philosophy;

(ii) Bathing;

(iii) Ambulation and exercise;

(iv) Personal grooming;

(v) Principles of nutrition and meal preparation;

(vi) Health conditions;

(vii) Developmental stages and mental status;

- (viii) Household services essential to health care at home;
- (ix) Assistance with medication;
- (x) Safety in the home;
- (xi) Completion of appropriate records;
- (xii) Reporting changes to appropriate supervisor; and
- (xiii) At least four (4) hours covering Alzheimer's disease and

dementia to include:

- (a)* Communication skills;
- (b)* Problem solving with challenging behaviors;
- (c)* Assistance with daily living; and
- (d)* Explanation of Alzheimer's disease and other dementias.

(j)(1) Aides shall receive a minimum of twelve (12) hours in-service training per twelve (12) months.

(2) The in-services provided shall address areas that directly relate to the patient care aspects of the aides' job.

(k) Homemaker services shall be available and adequate in frequency to meet the patient's needs.

20 CAR § 47-117. Plan of care.

(a) A written plan of care shall be established, maintained, and provided for each patient admitted to a hospice program.

(b)(1) The plan shall include:

- (A) An assessment of the patient's needs; and
- (B) Identification of the services, including the management of discomfort and symptom relief.

(2) It shall state in detail the scope and frequency of services needed to meet the patient's and family's needs.

(c) A written plan of care shall be:

- (1) Developed by the attending physician, the medical director or physician designee, and interdisciplinary group prior to providing care; and

(2)(A) Reviewed and revised to reflect the patient's and family's current needs, by the:

- (i) Attending physician;
- (ii) Medical director or physician designee; and
- (iii) Interdisciplinary group.

(B) The reviews shall be documented.

(d) Content of plan.

(1) The plan must include:

(A) Assessment of the individual's needs; and

(B) Identification of the services, including the management of discomfort and symptom relief.

(2) It must state in detail the scope and frequency of services needed to meet the patient's and family's needs.

20 CAR § 47-118. Clinical records.

(a)(1) In accordance with accepted principles of practice, the hospice shall establish and maintain a clinical record for every patient receiving care and services.

(2) The record ~~shall be~~:

(A) ~~Complete~~ Shall be complete;

(B) ~~Accurate~~ Shall be accurate;

(C) ~~Readily~~ Shall be readily accessible; ~~and~~

(D) ~~Systematically~~ Shall be systematically organized to facilitate retrieval;

and

(E) May be recorded in an electronic format.

(b) Content.

(1) Entries shall be:

(A) Made for the day services are provided; and

(B) Filed within seven (7) days.

(2) Entries shall be signed by the person providing the services.

(3) All entries shall be legible and readily accessible.

(4) The record shall include all services, whether furnished directly or under arrangement.

(5) Each patient's record shall contain the following:

- (A) Initial and subsequent assessments;
- (B) Plan of care;
- (C) Identification data;
- (D) Consent, authorization, and election forms;
- (E) Pertinent medical history; and
- (F) Documentation of all services and events.

(c) **Protection of information.** The hospice shall use reasonable precautions to safeguard the clinical record against:

- (1) Loss;
- (2) Destruction; and
- (3) Unauthorized use.

(d) **Record retention.** Closed records shall be retained for a minimum of five (5) years.

20 CAR § 47-119. Medical supplies/medications.

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

(b) **Administration.** All drugs and biologicals shall be administered in accordance with accepted standards of practice.

(c) **Controlled drugs in the patient's home.**

(1) Controlled substances no longer required by a patient receiving in-home hospice services may be disposed of by:

- (A) The owner of the prescription; or
- (B) A family member of a deceased patient to whom the controlled substances were dispensed.

(2) If requested, the controlled substances may be disposed of in the presence of a hospice nurse, in which case the nurse shall document the disposal by:

(A) Completing the Report of Drugs Surrendered Form; and
(B) Returning it to the Division of Pharmacy Services and Drug Control of the Department of Health.

(3) The patient or family member shall keep the blue copy of the report while the nurse:

- (A) Places the yellow copy in the medical record; and
- (B) Returns the white copy to the division.

(d) **Administration of pharmaceuticals.** A licensed nurse, physician, patient, or caregiver shall administer pharmaceuticals.

20 CAR § 47-120. Short-term inpatient care.

Inpatient care shall be:

(1) Available for:

- (A) Pain control;
- (B) Symptom management; and
- (C) Respite purposes; and

(2) Provided in licensed facilities, as stated below:

(A) **Inpatient care for symptom control.**

(i) Inpatient care for pain control and symptom management shall be provided in one (1) of the following:

(a) A hospice that meets the requirements for providing inpatient care directly as specified in 20 CAR § 47-121, inpatient direct care.; or

(b) A hospital or a skilled nursing facility (SNF);

(ii) Each shift shall include a registered nurse onsite to supervise and provide direct patient care; and

(B) **Inpatient care for respite purposes.** Inpatient care for respite purposes shall be provided by one (1) of the following:

(i) A hospice that meets the requirements for providing inpatient care directly as specified in 20 CAR § 47-121, inpatient direct care; or

(ii) A hospital, skilled nursing facility (SNF), or nursing facility.

20 CAR § 47-121. Inpatient direct care.

(a) In addition to the preceding sections, inpatient direct care shall also comply with 20 CAR §§ 47-121 – 47-132.

(b) Administration shall be responsible for the following:

(1)(A) Policies and procedures shall be provided for:

- (i) The general administration of the institution; and
- (ii) Each department, section, or service in the facility.

(B) All policies and procedures for departments or services shall have evidence of ongoing review and/or revision.

(C) The first page of each manual shall have the:

- (i) Annual review date; and
- (ii) Signature of the department supervisor and/or person or persons conducting the review;

(2)(A) The facility shall have visitation policies determined by the medical staff, governing body, and administration which comply with the No Patient Left Alone Act, Arkansas Code § 20-6-401 et seq.

(B) Patients shall be permitted to receive visitors at any hour, including small children and clergy members.

(C) Visitation restriction may include:

- (i) When the presence of a visitor would be medically or therapeutically contraindicated;
- (ii)(a) If the person has signs or symptoms of a transmittable disease.

(b) The facility shall allow access through telephone, telecommunications, or other means when visitation is restricted by subdivision (b)(2)(C)(i) of this section or subdivision (b)(2)(C)(ii) of this section;

- (iii) At the request of the patient, law enforcement, or court order;
- (iv) If the presence of a visitor would interfere with the care of or rights of any patient; and

(v) If the person is determined to be:

(a) A danger to:

(1) Staff;

(2) Other patients; or

(3) Visitors;

(b) Noncompliant with healthcare facility policies; or

(c) Engaging in disruptive, threatening, or violent behavior

toward any:

(1) Staff member;

(2) Patient; or

(3) Other visitor.

(D) The healthcare facility may require the clergy member to comply with reasonable health and safety precautions, including reasonable health screenings and wearing personal protective equipment, imposed by the healthcare facility in connection with in-person visitation for the prevention of the spreading of communicable disease unless the precautions substantially burden the ability of the clergy member to freely exercise his or her religion.

(E) If the requirements substantially burden the ability of the clergy member, the healthcare facility may require compliance with the precautions only if compliance in that instance furthers a compelling government interest and imposes the least restrictive burden on the clergy member's exercise of religion.

(F) Notwithstanding any other provision in Arkansas Code § 20-6-101 et seq., a healthcare facility may restrict visits of a clergy member who fails a reasonable health screening measure or tests positive for a communicable disease; and

(3)(A) Disaster preparedness.

(B) A written disaster preparedness plan shall be developed and communicated to staff through:

(i) Orientation;

(ii) Education; and

(iii) Ongoing reviews.

(C) The plan shall include:

(i) A definition of “disaster” for the hospice inpatient facility’s given location and circumstances;

(ii) Arrangements for prompt identification and transfer of patients and records to another facility if necessary;

(iii) Arrangements for coordination of community resources; and

(iv) Menus to coincide with a twenty-four-hour supply of perishable and seventy-two-hour supply for nonperishable food available for emergencies.

(c) Nursing.

(1)(A) The facility shall provide twenty-four-hour nursing service sufficient to meet patient needs in accordance with the patient plan of care.

(B) Each patient:

(i) Receives treatments, medications, and diet as prescribed; and

(ii) Is kept:

(a) Comfortable;

(b) Clean;

(c) Well-groomed; and

(d) Protected from:

(1) Accident;

(2) Injury; and

(3) Infection.

(2)(A) Each shift shall include:

(i) A registered nurse onsite to supervise and provide direct patient care; and

(ii) One (1) other nursing personnel type (e.g., RN, LPN, and/or hospice aide).

(B) A ratio of at least one (1) nursing personnel to every four (4) patients shall be maintained from 7:00 a.m. to 7:00 p.m. and a ratio of one (1) to six (6) from 7:00 p.m. to 7:00 a.m.

(3) A registered nurse shall assign the patient care of each patient to other nursing personnel in accordance with the patient’s needs.

(d) Dietary.

(1) Meal service, menu planning, and supervision.

(2) The hospice shall:

(A)(i) Serve at least three (3) meals or their equivalent each day at regular times, with not more than fourteen (14) hours between an evening meal and breakfast.

(ii) Meals may be adjusted according to the request of and as tolerated by the patient;

(B) Procure, store, prepare, distribute, and serve all food under sanitary conditions in accordance with the current Rules Pertaining to Retail Food Establishments, 20 CAR pt. 170;

(C) Employ a registered dietician or have a formal agreement with a registered dietician who is responsible for:

(i) Planning menus that meet nutritional needs of each patient in accordance with the recommended dietary allowances of the Food and Nutrition Board of the National Research Council, National Academy of Sciences; and

(ii) Supervising the meal preparation and service to ensure the menu plan is followed;

(D) Have menus prepared by a registered dietitian for patients who require medically prescribed special diets; and

(E) Have bedtime and between-meal snacks or supplements available.

(e) Pharmaceutical service.

(1) Appropriate methods and procedures for the dispensing and administering of drugs and biologicals shall be developed.

(2) Whether drugs and biologicals are obtained from community or institutional pharmacists or stocked by the facility, the facility is responsible for:

(A) Drugs and biologicals for patients insofar as they are covered under the program; and

(B) Ensuring that pharmaceutical services are provided in accordance with:

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- (i) Accepted professional principles; and
- (ii) Appropriate federal, state, and local laws.

(3) In facilities that obtain drugs and biologicals from community or institutional pharmacies:

(A) The hospice shall have contractual arrangements to ensure services are available twenty-four (24) hours a day, seven (7) days a week to the patients in the hospice facility;

(B) All prescription medications in the facility shall be patient-specific and appropriately labeled; and

(C) No prescription drug floor stock shall be allowed in the facility.

(4) The hospice shall:

(A) Employ a licensed pharmacist or have a formal agreement with a licensed pharmacist to advise the hospice on ordering, storage, administration, disposal, and recordkeeping of drugs and biologicals; and

(B)(i) Have a pharmaceutical service committee that meets quarterly consisting of at least the:

- (a) Medical director;
- (b) Pharmacist;
- (c) Nurse manager; and
- (d) Administrator.

(ii) The committee shall be responsible for the following:

- (a) Serve as an advisory group to the medical staff;
- (b) Approve the policies and procedures for pharmaceutical service annually;
- (c) Approve medication formulary annually;
- (d) Approve floor stock annually; and
- (e) Discuss medication errors and adverse drug reactions.

(5) **Orders for medications.**

(A) All medications shall be ordered by the physician or credentialed licensed practitioner according to their scope of practice if approved by the medical staff and governing body.

(B) If the medication order is verbal:

(i) The physician shall give the order only to a:

(a) Licensed nurse;

(b) Pharmacist; or

(c) Another physician; and

(ii)(a) The individual receiving the order shall record and sign immediately.

(b) The prescribing physician shall sign in the time frame determined by hospice policy.

(6) **Administration of medication.** Medications shall be administered only by one (1) of the following individuals:

(A) Licensed personnel in accordance with their scope of practice; and

(B) The patient:

(i) With approval of the attending physician; and

(ii) According to hospice policy.

(7) **Control and accountability.**

(A) The pharmaceutical service has procedures for control and accountability of all drugs and biologicals throughout the facility.

(B) Drugs are dispensed in compliance with federal and state laws.

(C) Records of receipt and disposition of all controlled drugs are maintained in sufficient detail to enable an accurate reconciliation.

(D) The pharmacist determines:

(i) Drug records are in order; and

(ii) An account of all controlled drugs is maintained and reconciled.

(8) **Labeling of drugs and biologicals.** The labeling of drugs and biologicals:

(A) Is based on currently accepted professional principles; and

(B) Includes the appropriate accessory and cautionary instructions as well as the expiration date when applicable.

(9) **Storage.**

(A) In accordance with state and federal laws:

(i) All drugs and biologicals are locked and stored under proper temperature controls; and

(ii) Only authorized personnel shall have access to the keys.

(B) Scheduled drugs shall be maintained as required by federal and state regulations.

(10) **Drug disposal.** Controlled substances no longer required by a patient residing in an inpatient hospice shall be disposed of by:

(A) Returning unused medications; and

(B) A Report of Drugs Surrendered Form to the Division of Pharmacy Services and Drug Control of the Department of Health.

(f) **Linen.**

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

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

(g) **Pet therapy.**

(1) Therapy animals (birds, cats, dogs, and other animals):

(A) May be permitted to visit in the patient's room; and

(B) Shall not negatively affect the well-being of others.

(2) Animals shall have appropriate vaccinations and licenses.

(3) A veterinary record shall be kept on all therapy animals to:

(A) Verify vaccinations; and

(B) Be made readily available for review.

(4) Therapy pets shall not be allowed in food preparation, food storage, dining, or service areas.

(h) If personal pets are allowed in the facility, the facility will have policy and procedures consistent with local ordinances.

20 CAR § 47-122. Infection control for IPU.

(a)(1) There shall be a comprehensive list of communicable diseases for which:

- (A) Patients shall be isolated; and
- (B) There are visitation restrictions.

(2) The list and other policies and procedures for isolation shall conform to the latest edition of the Centers for Disease Control and Prevention Guidelines.

(b) There shall be policies and procedures established and followed for:

- (1) Sterilization;
- (2) Sanitary food preparation;
- (3) Housekeeping;
- (4) Linen care;
- (5) Separation of clean from dirty process; and
- (6) Use of disinfectants, antiseptics, and germicides according to the

manufacturer's directions.

20 CAR § 47-123. Physical environment.

(a)(1) A homelike setting design and functional program shall include the following:

(A) A place where all family members, including children, may come and go in a natural, family-like manner;

(B) Social areas where family members may:

- (i) Bring food and dine together; and
- (ii) Enjoy music, games, and other activities common to the family

unit; and

(C) A balance between privacy and opportunity for social interaction.

(2) **Patient areas.**

(A) Bedrooms, dining areas, lounges, and surroundings shall be designed to promote privacy and dignity for the patient and family.

(B) The interior design of patient-use areas shall consider lighting, the use of finish materials, furniture arrangement, and equipment to create a homelike ambience without compromising the ability of caregivers to attend to the needs of the patient.

(C) Patient toilet rooms shall be accessible and provide adequate space for staff assistance in wheelchair transfers as necessary for at least fifty percent (50%) of patient capacity.

(b) Building and grounds.

(1) The building and equipment shall be maintained in a state of good repair at all times.

(2)(A) Facilities and their premises shall be kept:

- (i) Clean and neat; and
- (ii) Free of litter and rubbish.

(B) The facility shall have written policies and procedures for housekeeping.

(3) Rooms for gas-fired equipment shall not be used for storage except for noncombustible materials.

(4) Portable equipment shall be:

- (A) Supervised by the department having control of such equipment; and
- (B) Stored in areas that are not accessible to:
 - (i) Patients;
 - (ii) Visitors; or
 - (iii) Untrained personnel.

(5)(A) Corridors, attics, and passageways shall be free of storage.

(B) Exits shall not be blocked by storage of furniture or equipment at any time.

(6)(A) Each hospice facility shall develop a written preventive maintenance plan including all electrically powered:

- (i) Patient care equipment;
- (ii) Physical plant equipment; and

(iii) Fire alarms and detection systems.

(B) This plan shall be available to the Department of Health for review at any time.

(C) Such plans shall:

(i) Provide for maintenance as recommended by the:

(a) Manufacturer;

(b) Applicable codes; or

(c) Designer; and

(ii) Ensure that equipment and systems perform properly and safely.

(7) Handwashing stations shall be available:

(A) In visitors' restrooms; and

(B) For use by staff personnel.

(8)(A) A supply of hot water for patient use shall be available at all times within the range of one hundred ten degrees Fahrenheit to one hundred twenty degrees Fahrenheit (110°F – 120°F).

(B) A weekly hot water temperature log shall be maintained.

(9)(A) Heating, ventilating, and air-conditioning systems shall be operated and maintained in a manner to provide a comfortable and safe environment for:

(i) Patients;

(ii) Personnel; and

(iii) Visitors.

(B) An air filter changeout log shall be maintained.

(10) **Steam and hot water systems and pressure vessels.**

(A) All pressure vessels shall meet the requirements of the Chief Inspector of the Boiler Inspection Division of the Division of Labor.

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

(c) **Maintenance and engineering — Emergency procedures program.**

(1) There shall be written emergency procedures or a disaster management plan for utility system disruptions or failures that address the specific and concise procedures to follow in the event of a:

(A) Utility system malfunction; or

(B) Failure of the:

(i) Water supply;

(ii) Hot water system;

(iii) Medical gas system;

(iv) Sewer system;

(v) Bulk waste disposal system;

(vi) Natural gas system;

(vii) Commercial power system;

(viii) Communication system;

(ix) Boiler; or

(x) Steam delivery system.

(2) These procedures shall be kept separate from all other policy and procedure manuals so as to facilitate their rapid implementation.

(3) These procedures shall contain but are not limited to the following information:

(A) A method of obtaining alternative sources of essential utilities;

(B) A method of shutoff and location of valves for malfunctioning systems;

(C) A method of notification of hospice staff in affected areas; and

(D) A method of obtaining repair services.

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

(1) Kept in containers that accurately reflect at least the following:

(A) Content name;

(B) Concentration of solution; and

(C) Expiration date and lot number; and

(2)(A) Stored in a secured area.

(B) Under no circumstances shall these substances be stored in or near food storage or food preparation areas.

(e) **Laundry services.** Facility laundry service:

(1) Sorting of soiled laundry shall be done in a designated area;

(2) Tables or bins shall be provided for sorting of soiled laundry;

(3) Lint traps shall be:

(A) Provided on dryers; and

(B) Cleaned regularly;

(4) Prerinsing shall be done in the laundry service, not in:

(A) Showers;

(B) Bathtubs; or

(C) Lavatories;

(5) Removal of solid soil shall be done in:

(A) Soiled utility rooms; or

(B) Rooms that are designated for this purpose;

(6) Patient clothing may be washed in the patient area if a separate equipped laundry room is available; and

(7) A rinsing sink shall be provided in the soiled linen area of the laundry.

20 CAR § 47-124. Physical facilities.

(a) **General considerations.**

(1) The requirements set forth herein:

(A) Have been established by the Department of Health; and

(B) Constitute minimum requirements for the design, construction, renovation, and repair of facilities requiring licensure under this part.

(2) Facilities shall be accessible to:

(A) The public;

(B) Staff; and

(C) Patients with physical disabilities.

(3)(A) Projects involving existing facilities shall be programmed and phased to minimize disruption of the existing functions.

(B) Access, exits, and fire protection shall be maintained for the occupants' and the facility's safety.

(4) Codes and standards.

(A) Nothing stated herein shall relieve the owner from compliance with building codes, ordinances, and regulations that are enforced by city, county, or other state jurisdictions.

(B) Where such codes, ordinances, and rules are not in effect, the owner shall consult the state building codes for all components of the building type that are not specifically covered by these minimum requirements.

(b) Occupancy.

(1) Each licensed facility or portion of a licensed facility shall be classified as indicated below.

(2) "Inpatient direct care hospice" means a licensed hospice facility that provides direct inpatient care to the terminally ill.

(c) **Multiple occupancy.** Facilities may contain more than one (1) occupancy provided each different occupancy is separated from all other occupancies by a two-hour fire-resistive-rated smoke barrier.

(d) **Construction projects.** Each construction project shall be classified as indicated below:

(1) New;

(2)(A) Addition.

(B) A project that increases the floor area of a licensed facility;

(3)(A) Repair.

(B) A project that provides for the repair or renewal of a licensed facility or portion of a licensed facility solely for the purpose of its maintenance;

(4)(A) Simple renovation.

(B) A project other than repair that meets all of the criteria listed below:

(i) The project does not increase the floor area of a licensed facility;

- (ii) The project does not change the occupancy of a:
 - (a) Licensed facility; or
 - (b) Portion of a licensed facility;
- (iii) The project does not involve more than two (2) smoke compartments; and
- (iv) The smoke compartments affected by the project were completely protected by an automatic sprinkler system prior to the project or the project provides for the installation of a complete automatic sprinkler system in all smoke compartments that are affected by the project; and

(5)(A) Complex renovation.

(B) A project other than addition, repair, or simple renovation.

(e) Applicable requirements based upon occupancy — Existing facilities.

Existing facilities that do not comply with this part shall be permitted to continue in service provided the lack of conformity with this part does not present a serious hazard to the occupants as determined by:

- (1) The Division of Health Facilities Services; or
- (2) Other authorities having jurisdiction.

(f) Applicable requirements based upon the type of project.

(1) General.

(A) Where renovation work is done within an existing facility, all new work, additions, or both shall comply insofar as practical with:

- (i) Applicable sections of this part; and
- (ii) Appropriate sections of the National Fire Protection Association's NFPA 101: Life Safety Code covering new occupancies.

(B)(i) In renovation projects and projects involving additions to existing facilities, only that portion of the total facility affected by the project shall comply with:

- (a) Applicable sections of this part; and
- (b) Appropriate parts of the National Fire Protection Association's NFPA 101: Life Safety Code covering new occupancies.

(ii) Existing portions of the facility that are not included in the project but are essential to the functioning of a complete facility shall comply, at a minimum, with the appropriate sections of the National Fire Protection Association's NFPA 101: Life Safety Code covering existing occupancies.

(iii) Existing portions of the facility that receive less than substantial amounts of new work shall also comply, at a minimum, with the appropriate sections of the National Fire Protection Association's NFPA 101: Life Safety Code covering existing occupancies.

(C) Facilities or portions of facilities shall be permitted to be occupied during construction, renovation, and repair only where:

(i) Required means of egress and required fire protection features are in place and continuously maintained for the portion occupied; or

(ii) Alternate life safety measures acceptable to the Division of Health Facilities Services and other authorities having jurisdiction are in place.

(2) New, addition, simple renovation, and complex renovation shall be designed, constructed, and renovated in accordance with:

(A) The applicable sections of this part; and

(B) All appendices and publications referenced by these sections.

(3) Repair projects shall be designed and constructed in a manner that does not diminish the safety level that existed prior to the start of the work.

(g) Project review and approval process.

(1) Coordination.

(A) The Division of Health Facilities Services will coordinate the review and approval process for all offices of the Department of Health.

(B) An entity may utilize a private professional provider for project review and approval process in accordance with the Fast-Track Permits Act, Arkansas Code §14-1-501, et seq.

(2) New, addition, simple, or complex renovation projects shall be reviewed and approved by the Division of Health Facilities Services as indicated below:

(A) Drawing review and approval process.

(i) **Submission of plan review fee.**

(a) A plan review fee in the amount of one percent (1%) of the total cost of construction or five hundred dollars (\$500), whichever is less, shall be paid for the review of plans and specifications.

(b) The plan review fee check is to be made payable to the Department of Health.

(c) A detailed estimate shall accompany the plans unless the maximum fee of five hundred dollars (\$500) is paid.

(ii) Submission of functional program and cost estimate.

(iii) Submission of site location.

(iv) Submission of preliminary plans.

(v) **Review of functional program, site location, and preliminary plans.** The Division of Health Facilities Services shall review the functional program, site location, and preliminary plans and forward a written response with comments to the facility.

(vi) Submission of final construction documents.

(vii) **Review and approval of final construction documents.**

(a) The Division of Health Facilities Services shall review the final construction documents and forward a written response with comments to the facility.

(b) The Division of Health Facilities Services shall have a minimum of six (6) weeks to review final construction documents.

(c) The written response shall indicate whether or not the final construction documents are approved.

(d) If the final construction documents are not approved, the written response shall indicate the design modifications required to secure approval;

(B) **Approval to begin construction.** Facilities may proceed with new construction or addition, simple, or complex renovation projects after receiving:

(i) A letter from the Division of Health Facilities Services stating that the final construction documents have been reviewed and approved; and

(ii) Approval from other authorities having jurisdiction;

- (C) Site inspections during construction; and
- (D) Final site inspection.

(3) **Repair.** Repair projects do not require the Division of Health Facilities Service's review and approval.

(h) **Site location.**

(1) **Roads and parking.**

(A)(i) Paved roads and walks shall be provided within the lot lines to provide access to the main entrance and service entrance, including loading and unloading docks for delivery trucks.

(ii) Paved walkways shall be provided for necessary pedestrian traffic.

(B)(i) Each facility shall have parking spaces to satisfy the minimum needs of patients, employees, staff, and visitors.

(ii) In the absence of a formal parking study, each facility shall provide not less than one (1) space for each:

(a) Day shift staff member; and

(b) Patient bed.

(iii) This ratio may be reduced in an area convenient to a public transportation system or to a public parking facility:

(a) If proper justification is given; and

(b) Provided that approval of any reduction is obtained from the Department of Health.

(2) **Subsoil investigation.**

(A) Subsoil investigation shall be made to determine the subsurface soil and water conditions.

(B) The investigation shall include a sufficient number of test pits or test borings to determine, in the judgment of the architect and the structural engineer, the true subsurface conditions.

(C) Results of the investigation shall be available in the form of a:

(i) Soil investigation report; or

(ii) Foundation engineering report.

(D) The investigation shall:

(i) Be made in close cooperation with the architect and structural engineer; and

(ii) Contain detailed recommendations for foundation design and gradings.

(3) **Approval.** The new building site shall be inspected and approved by the Department of Health before construction begins.

(i) **Preliminary plans.** Preliminary plans submitted to the Division of Health Facilities Services shall include as a minimum the following information:

(1) Floor plans drawn to scale that indicate:

(A) Room names;

(B) Room dimensions;

(C) Corridor dimensions;

(D) Locations of fire-resistive-rated partitions; and

(E) Locations of rated smoke barriers;

(2) An existing floor plan indicating existing spaces and exits and their relationship to the new construction (renovation projects only);

(3)(A) Building sections that establish the proposed construction type and fire rating.

(B) Sections shall be drawn at a scale sufficiently large to clearly present the proposed construction system;

(4) A site plan that indicates the location of proposed:

(A) Roads;

(B) Walks;

(C) Service and entrance courts;

(D) Parking; and

(E) Orientation;

(5) Simple horizontal and vertical space diagrams that indicate the:

(A) Relationship of various departments and services to each other; and

(B) General room arrangement in each department; and

(6) A narrative description of proposed mechanical, electrical, and fire protection systems.

(j) **Final construction documents.**

(1) Construction documents shall be prepared by an architect and/or professional engineer licensed by the State of Arkansas.

(2)(A) Architectural construction documents shall be prepared by an architect and engineering construction documents (structural, mechanical, electrical, and civil) shall be prepared by a qualified engineer.

(B) The documents shall be stamped with appropriate seals for each discipline.

(3)(A) Periodic observations of construction shall be provided and documented by each design professional.

(B) Design professionals shall verify that the:

(i) Construction is in accordance with the construction documents;

and

(ii) Record drawings are properly maintained.

(4) The construction contract shall contain a provision to withhold progress payments to the contractor until the record drawings are current.

(5)(A) Final construction documents shall include drawings and specifications.

(B) Separate drawings and specifications shall be prepared for each of the following branches of work:

(i) Architectural;

(ii) Structural;

(iii) Mechanical;

(iv) Electrical;

(v) Life safety; and

(vi) Fire protection.

(C) **Specifications.** Specifications shall:

(i) Supplement the drawings to fully describe types, sizes, capacities, workmanships, finishes, and other characteristics of all materials and equipment; and

(ii) Include the following:

- (a) Cover or title sheet with architectural seal;
- (b) Index;
- (c) General conditions;
- (d) General requirements; and
- (e) Sections describing material and workmanship in detail for

each class of work.

(D)(i) All construction documents and specifications shall be approved by the Department of Health prior to the beginning of construction and a letter shall be issued from the licensing agency granting approval to commence with construction.

(ii) The Department of Health shall have a minimum of six (6) weeks to review construction documents and specifications.

(iii) The Division of Health Facilities Services shall coordinate the plan review with other divisions in the Department of Health.

(k) **Site inspection during construction.** The Department of Health shall inspect the project during the construction process as indicated below:

(1) The Department of Health is to be notified when construction begins and a construction schedule shall be submitted to determine inspection dates;

(2) Representatives from the Department of Health shall have access to the construction premises and the construction project for purposes of making whatever inspections deemed necessary throughout the course of construction; and

(3) Any deviation from the accepted construction documents shall not be permitted during construction until the written request for change or changes in the construction is approved by the Department of Health.

(l) **Final site inspection.**

(1) Upon completion of construction and prior to the approval by the Department of Health to occupy and use the facility, the owner shall be furnished a complete set of record drawings and a complete set of installation, operation, and maintenance manuals and parts lists for the installed equipment.

(2) A list of final site inspection items has been provided in Table 5 of the Appendix.

(3) No facility shall occupy any new structure or major addition or renovation space until the appropriate permission has been received from the:

- (A) Local building and fire authorities; and
- (B) Licensing agency.

20 CAR § 47-125. Physical facilities — Patient accommodations for hospice.

(a) **Patient rooms.** Each patient room shall meet the following requirements.

(1) Maximum room capacity shall be two (2) patients.

(2)(A) In new construction, patient rooms shall have a minimum of one hundred square feet (100 sq. ft.) of clear floor area per bed in semiprivate rooms and one hundred twenty square feet (120 sq. ft.) of clear floor area for single-bed rooms, exclusive of:

- (i) Toilet rooms;
- (ii) Closets;
- (iii) Lockers;
- (iv) Wardrobes;
- (v) Alcoves; or
- (vi) Vestibules.

(B) The dimensions and arrangement of rooms shall be such that there is a minimum of three feet (3') between the sides and foot of the bed and:

- (i) Any wall;
- (ii) Other fixed obstruction; or
- (iii) Another bed.

(C) In semiprivate bedrooms, a clearance of four feet (4') shall be available at the foot of each bed to permit the passage of equipment and beds.

(3)(A) Minor encroachments, including columns and lavatories, that do not interfere with functions may be ignored when determining space requirements for patient rooms.

(B) Where renovation work is undertaken, every effort shall be made to meet the above minimum standards.

(4)(A) Each patient room:

(i) Shall have a window with outside exposure; and

(ii) Where the operation of windows or vents requires the use of tools or keys, such devices shall be on the same floor and easily accessible to staff.

(B) The windowsills:

(i) Shall not be higher than three feet (3') above the floor; and

(ii) Shall be above the grade.

(C) Patient rooms in new construction intended for twenty-four-hour occupancy shall have windows.

(D) If operable windows are installed, such devices shall be restricted to inhibit possible escape or suicide.

(5)(A) Each patient shall have access to a toilet room without having to enter the general corridor area.

(B) One (1) toilet room shall serve no more than:

(i) Four (4) patient beds; and

(ii) Two (2) patient rooms.

(C) In new construction, an additional hand washing station or sanitizing station shall be placed in the patient room where the toilet room serves more than one (1) bed.

(D) The toilet room shall contain a water closet and a hand washing station and the door shall swing outward or be double-acting;

(6) Each patient shall have within the room a separate wardrobe or closet that is suitable for:

(A) Hanging full-length garments; and

(B) Storing personal items.

(7)(A) Visual privacy from casual observation by other patients and visitors shall be provided for each patient in semiprivate rooms with:

- (i) Cubicle curtains; or
- (ii) Equivalent built-in or movable dividers.

(B) The method for providing privacy shall not obstruct passage of other patients to the:

- (i) Entrance;
- (ii) Toilet; or
- (iii) Lavatory.

(C) All curtains shall:

- (i) Have a flame spread of zero (0) to twenty-five (25); and
- (ii) Comply with the National Fire Protection Association's NFPA 13:

Standard for the Installation of Sprinkler Systems requirements for clear space below sprinklers.

(8) Each room shall connect directly with a corridor without passage through another patient's room.

(9) Rooms existing partially below grade level shall not be used for patients unless they are:

- (A) Dry;
- (B) Well-ventilated; and
- (C) Otherwise suitable for occupancy.

(10) Beds shall be arranged to:

- (A) Provide adequate room for all patient care procedures; and
- (B) Prevent the transmission of infections.

(11)(A) Suitable beds shall be provided.

(B) Bed rails shall be provided on beds for children.

(12)(A) A reading light shall be provided for each patient bed.

(B) The location and design shall be such that the light is not annoying to other patients.

(13)(A) A bedside table with drawer shall be provided for each bed.

(B) The lower portion of the table and/or enclosed shelves shall be provided for individual nursing care equipment.

(14)(A) A bathing facility containing either a bathtub or a shower accessible to a wheeled shower chair shall be conveniently accessible to patient rooms.

(B) An accessible toilet room shall be accessible to the bathing room.

(b) **Service areas.**

(1) Each service area may be arranged and located to serve more than one (1) nursing unit, but at least one (1) such service area shall be provided on each nursing floor.

(2) Some of the service areas may be combined in a single space.

(3) The following service areas shall be located in or readily available to each nursing unit:

(A)(i) Nursing station.

(ii) Facilities for charting, clinical records, work counter, communication system, space for supplies, and convenient access to hand washing stations shall be provided.

(iii) It may be combined with or include centers for reception and communication;

(B)(i) Dictation area shall be provided.

(ii) This area shall be adjacent to but separate from the nurses' station;

(C)(i) Toilet room or rooms for staff convenient to nurses' station.

(ii) May be unisex;

(D) Multipurpose room or rooms for:

(i) Staff;

(ii) Patients;

(iii) Patients' families for patient conferences;

(iv) Reports;

(v) Education;

(vi) Training sessions; and

(vii) Consultation;

(E)(i) Clean workroom or clean supply room.

(ii) If the room is used for preparing patient care items, it shall

contain:

(a) A work counter;

(b) A hand washing fixture; and

(c) Storage facilities for clean and sterile supplies.

(iii) If the room is used only for storage and holding as part of a system for distribution of clean and sterile materials, the work counter and hand washing fixture may be omitted.

(iv) Soiled and clean workrooms or holding rooms shall:

(a) Be separated; and

(b) Have no direct connection;

(F)(i) Soiled workroom or soiled holding room.

(ii) This room shall be separate from the clean workroom.

(iii) The soiled workroom shall contain a clinical sink or equivalent flushing-rim fixture.

(iv) The room shall contain a lavatory or hand washing fixture.

(v) The above fixtures shall both have a hot and cold mixing faucet.

(vi) The room shall have:

(a) A work counter; and

(b) Space for separate covered containers for soiled linen and waste.

(vii) Rooms used only for temporary holding of soiled material may omit the clinical sink and work counter.

(viii) If the flushing-rim clinical sink is eliminated, facilities for cleaning bedpans shall be provided elsewhere;

(G)(i) Medication station.

(ii) Provisions shall be made for distribution of medications.

(iii) This may be done:

- (a)* From a medicine preparation room or unit;
- (b)* From a self-contained medicine dispensing unit; or
- (c)* By another approved system;

(iv) Medicine preparation room.

(a) This room shall be designed to allow for visual supervision by the nursing staff.

(b) It shall contain:

- (1)* A work counter;
- (2)* A sink adequate for hand washing;
- (3)* A refrigerator; and
- (4)* Locked storage for controlled drugs.

(c) When a medicine preparation room is to be used to store one (1) or more self-contained medicine dispensing units, the room shall be designed with adequate space to prepare medicines with the self-contained medicine dispensing unit or units present.

(v) Self-contained medicine dispensing unit.

(a) A self-contained medicine dispensing unit may be located at the nurses' station, in the clean workroom, or in an alcove, provided the unit has adequate:

- (1)* Security for controlled drugs; and
- (2)* Lighting to easily identify drugs.

(b) Convenient access to hand washing stations shall be provided.

(c) Standard cup sinks provided in many self-contained units are not adequate for hand washing;

(H)(i) Nourishment station.

(ii) This shall contain:

- (a)* A sink equipped for handwashing;
- (b)* Equipment for serving nourishment between scheduled and

unscheduled meals;

(c) A refrigerator;
(d) Storage cabinets; and
(e) Icemaker units to provide ice for patients' service and treatment.

(iii) Ice for human consumption shall be from self-dispensing units.
(iv) Hand washing stations shall be in or immediately accessible to the nourishment station;

(I)(i) Equipment storage room.

(ii) This shall be for equipment such as:

- (a) IV stands;
- (b) Inhalators;
- (c) Air mattresses;
- (d) Walkers; and
- (e) Wheelchairs; and

(J) A comfortable and easily accessible sleep area for family members.

(c) A common kitchen area if provided shall contain a:

- (1) Refrigerator;
- (2) Sink; and
- (3) Microwave.

(d) Dining and/or gathering space for patients and families shall be provided as required by the narrative program.

(e) **Airborne infection isolation room or rooms.** Rooms for patients who are suffering from airborne infections shall be provided at the rate of one (1) for every thirty-six (36) beds or fraction thereof.

20 CAR § 47-126. Physical facilities — Pharmacy.

(a)(1) The size and type of services to be provided in the pharmacy can largely depend upon the:

- (A) Type of medication distribution system used;
- (B) Number of patients to be served; and

- (C) Extent of shared or purchased services.
- (2) This shall be described in the narrative functional program.
- (3) The pharmacy room or suite shall be located for:
 - (A) Convenient access;
 - (B) Staff control; and
 - (C) Security.
- (4) Facilities and equipment shall be as necessary to accommodate the functions of the program.
- (5) See 20 CAR § 47-121(e), pharmaceutical service, for additional requirements.
- (b) At a minimum, the following elements shall be included:
 - (1)(A) Dispensing.
 - (B) A pickup and receiving area.
 - (C) An area for reviewing and recording.
 - (D) An extemporaneous compounding area that includes:
 - (i) A sink; and
 - (ii) Sufficient counter space for medication preparation.
 - (E) Work counters and space for automated and manual dispensing activities.
 - (F) An area for temporary storage, exchange, and restocking of carts.
 - (G) Security provisions for medications and personnel in the dispensing counter area;
 - (2)(A) Manufacturing.
 - (B) A bulk compounding area.
 - (C) Provisions for packaging and labeling.
 - (D) A quality control area;
 - (3)(A) Storage (may be cabinets, shelves, and/or separate rooms or closets).
 - (B) Bulk storage.
 - (C) Active storage.
 - (D) Refrigerated storage.

(E) Volatile fluids and alcohol storage constructed according to applicable fire safety codes for the substances involved.

(F) Double-locked storage for controlled substances.

(G) Storage for general supplies and equipment not in use;

(4)(A) Administration.

(B)(i) An area for education and training.

(ii) May be in a multipurpose room shared with other departments.

(C) A separate area for office functions; and

(5)(A) Other.

(B) Hand washing facilities stations shall be provided within each separate room where open medication is handled and readily accessible.

(C) Provide for convenient access to toilet and locker.

(D) If unit dose procedure is used, provide additional space and equipment for supplies, packaging, labeling, and storage, as well as for the carts.

(E)(i) If IV solutions are prepared in the pharmacy, provide a sterile work area with a laminar-flow workstation designed for product protection.

(ii) The laminar-flow system shall:

(a) Include a nonhygroscopic HEPA filter rated at ninety-nine and ninety-seven hundredths percent (99.97%) as tested by DOP tests; and

(b) Have a visible pressure gauge for detection of filter leaks or defects.

(F) Hoods used for chemotherapy shall be one hundred percent (100%) exhausted to the exterior.

(G) At a minimum, the partitions enclosing the pharmacy shall extend from the floor to the deck above with gypsum board on both sides of metal studs.

20 CAR § 47-127. Physical facilities — Waste processing services.

(a) Hazardous waste and antineoplastic agent disposal.

(1) The facility shall have policies and procedures for the identification, segregation, labeling, storage, transport, and disposal of hazardous waste.

(2) The policies and procedures shall conform with the latest edition of Hazardous Waste Management, 8 CAR pt. 81, Division of Environmental Quality, Little Rock, Arkansas.

(3) Within the facility, hazardous waste, especially antineoplastic agents, shall be labeled in a manner that it shall be easily recognized from all other waste.

(4) The facility shall compile a list of all antineoplastic agents used in the facility.

(5) The facility shall have policies and procedures for:

(A) The cleanup of spills; and

(B) Decontamination and treatment of personnel exposed to hazardous waste and antineoplastic agents.

(b) Regulated medical waste (infectious waste) disposal.

(1) The facility shall have policies and procedures for the identification, segregation, labeling, storage, transport, and disposal of regulated medical waste.

(2) All policies and procedures shall conform to the latest edition of the Rules Pertaining to the Management of Medical Waste from Generators and Healthcare Related Facilities, 20 CAR pt. 53, Department of Health, Little Rock, Arkansas.

(3) The facility shall have policies and procedures for:

(A) The cleanup of spills; and

(B) Decontamination and treatment of personnel exposed to regulated medical waste.

(c) Solid waste disposal — Noninfectious waste.

(1) The facility shall have policies and procedures for the identification, segregation, labeling, storage, transport, and disposal of solid waste.

(2) Policies and procedures shall conform with the latest edition of the Solid Waste Management Rules, 8 CAR pt. 60, Department of Energy and Environment, Little Rock, Arkansas.

(d) **Other waste.** The facility shall have policies and procedures for the identification, segregation, labeling, storage, transport, and disposal of any waste not specifically mentioned in this section.

20 CAR § 47-128. Physical facilities — Details and finishes.

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

(b) Details.

(1) Compartmentation, exits, automatic extinguishing systems, and other details relating to fire prevention and fire protection shall:

(A) Comply with requirements listed in the NFPA-referenced codes; and

(B) Be maintained at the facility and shown on the fire protection plan.

(2)(A) Corridor partitions, smoke stop partitions, horizontal exit partitions, exit enclosures, and fire-rated walls required to have protected openings shall be effectively and permanently identified with signs or stenciling in a manner acceptable to the Division of Health Facilities Services.

(B) Such identification shall be:

(i) Above any decorative ceiling; and

(ii) In concealed spaces.

(3) Rooms containing bathtubs, sitz baths, showers, and water closets, subject to occupancy by patients, shall be equipped with doors and hardware that shall permit access from outside the room.

(4)(A) Glass doors, lights, sidelights, borrowed lights, and windows located within twelve inches (12") of a door jamb, with a bottom frame height of less than sixty inches (60") above the finished floor, shall be constructed of:

(i) Safety glass;

(ii) Wired glass; or

(iii) Plastic, break-resistant material that creates no dangerous cutting edges when broken.

(B) Safety glass-tempered or plastic glazing materials shall be used for shower doors and bath enclosures.

(C) In renovation projects, only glazing within eighteen inches (18") of the floor shall be changed to:

- (i) Safety glass;
- (ii) Wired glass; or
- (iii) Plastic, break-resistant material.

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

(B) Expansion and seismic joints shall be constructed to restrict the passage of smoke.

(6)(A) Grab bars shall be provided in all patients' toilets, showers, tubs, and sitz baths.

(B) The bars shall have:

- (i) One-and-one-half-inch clearance to walls; and
- (ii) Sufficient strength and anchorage to sustain a concentrated load of two hundred fifty pounds (250 lbs.).

(7) Lavatories and hand washing stations shall be securely anchored to withstand an applied downward vertical load of not less than two hundred fifty pounds (250 lbs.) on the front of the fixture.

(8) The minimum ceiling height shall be seven feet ten inches (7' 10") with the following exceptions:

(A) Boiler rooms shall have ceiling clearances not less than two feet six inches (2' 6") above the:

- (i) Main boiler header; and
- (ii) Connecting piping;

(B)(i) Ceilings in corridors, storage rooms, and toilet rooms shall be not less than seven feet eight inches (7' 8") in height.

(ii) Ceiling heights in small, normally unoccupied spaces may be reduced; and

(C) Where existing structures make the above ceiling clearance impractical, clearances shall be as required to avoid injury to individuals up to six feet four inches (6' 4") tall.

(9) Rooms containing heat-producing equipment such as boiler or heater rooms and laundries shall be insulated and ventilated to prevent any floor or partition surface from exceeding a temperature of ten degrees Fahrenheit (10°F) above ambient room temperature.

(10)(A) Noise reduction criteria shown in Table 2 of the Appendix shall apply to partition, floor, and ceiling construction in patient areas.

(B) Careful attention shall be given to penetrations.

(11)(A) Light fixtures shall be provided with protective covers in:

- (i) Food preparation and serving areas; and
- (ii) Patient care and treatment spaces.

(B) Protective light fixture covers are not required in corridors.

(12) Handrails shall be provided in all corridors used by patients.

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

20 CAR § 47-129. Physical facilities — Construction, including fire-resistive requirements.

(a) **Design.** Every building and every portion thereof shall be designed and constructed to sustain all dead and live loads in accordance with the American Society of Civil Engineers ASCE Standard 7-93: Minimum Design Loads for Buildings and Other Structures.

(b) Foundations.

(1) Foundations shall rest on natural solid bearing if a satisfactory bearing is available at reasonable depths.

(2) Proper soil-bearing values shall be established in accordance with recognized standards.

(3) If solid bearing is not encountered at practical depths, the structure shall be supported on drive piles or drilled piers designed to support the intended load without detrimental settlement, except that one-story buildings may rest on a fill designed by a soils engineer.

(4) When engineered fill is used, site preparation and placement of fill shall be performed under the direct full-time supervision of the soils engineer.

(5) The soils engineer shall issue:

(A) A final report on the compacted fill operation; and

(B) Certification of compliance with the job specifications.

(6) All footings shall extend to a depth not less than one foot (1') below the estimated maximum frost line.

(c) **Construction.**

(1)(A) Construction shall comply with the applicable requirements of NFPA 101 and the Arkansas Fire Prevention Code, Volumes I and II, and Title 22, Subchapter B, Building Authority Minimum Standards and Criteria, Part 111 Design Review Section, Accessibility for Individuals with Disabilities Standards, 22 CAR § 111-1001 et seq.

(B) **Note.** NFPA 101 generally covers fire/safety requirements only, whereas most model codes also apply to structural elements.

(C) The fire/safety items of NFPA 101 would take precedence over other codes in case of conflict.

(D) In the event NFPA 101 does not specifically address a life safety requirement found only in the Arkansas Fire Prevention Code, compliance with the requirement is not mandatory.

(E) Appropriate application of each would minimize problems.

(F) For example, some model codes require closers on all patient doors.

(G) NFPA 101 recognizes the potential fire/safety problems of this requirement and stipulates that if closers are used for patient room doors, smoke detectors shall also be provided within each affected patient room.

(2)(A) For renovation projects, the extent of new construction shall be determined by the licensing agency.

(B) Construction shall comply with applicable requirements of NFPA 101.

(d) **Elevators.**

(1) All facilities located on other than the grade-level entrance floor shall have electric or hydraulic elevators.

(2) Elevator cars shall have inside dimensions that accommodate a patient bed with attendants.

(3) Cars shall be at least five feet eight inches wide by nine feet deep (5' 8" x 9').

(4) Car doors shall have a clear opening of not less than four feet wide and seven feet high (4' x 7').

(5) In renovations, existing elevators that can accommodate patient beds used in the facility will not be required to be increased in size.

(6) **Note.** Additional elevators installed for visitors and material handling may be smaller than noted above, within restrictions set by standards for disabled access.

20 CAR § 47-130. Physical facilities — Plumbing and other piping systems.

All plumbing systems shall be designed and installed in accordance with the requirements of the latest edition of the:

- (1) Arkansas Plumbing Code, 17 CAR pt. 65; and
- (2) Boiler Inspection Rules, 20 CAR pt. 880, Department of Labor and Licensing.

20 CAR § 47-131. Physical facilities — Electrical standards.

(a) Lighting.

(1) Approaches to buildings and parking lots and all occupied spaces within buildings shall have fixtures that can be illuminated as necessary.

(2) Patient rooms shall have general lighting and night lighting.

(3) Nursing unit corridors shall have general illumination with provisions for reducing light levels at night.

(4) Egress and exit lighting shall comply with NFPA 101.

(b) Nurse/patient communication station.

(1) A nurse/patient communication system shall be provided for each patient bedside in accordance with the functional program.

(2) An emergency call system shall be provided in each patient's:

(A) Toilet;

(B) Bath; and

(C) Shower room.

(c) Emergency electrical generators shall have a minimum forty-eight (48) hours of onsite fuel.

(d) All healthcare occupancies shall be provided with a fire alarm system in accordance with NFPA 101 and NFPA 72.

20 CAR § 41-132. ~~Satellite office or alternate delivery site~~Multiple location.

(a)(1) A licensed agency shall file an application under oath with the Department of Health upon forms prescribed by the department prior to beginning operation of a ~~satellite office~~multiple location.

(2) The department will:

(A) Review the application; and

(B) Issue a written approval or denial of the application.

(b) A ~~satellite office~~multiple location must provide the same full range of services that is required of the licensed parent hospice.

(c) The governing body and administration of the parent hospice must be able to exert the supervision and control necessary to ensure that all hospice services continue to be responsive to the needs of the patient/family.

(d) Each patient of the ~~satellite office~~multiple location must be assigned to a specific IDG.

(e)(1) Current active patient records will be maintained by the ~~satellite office~~multiple location but must be available to the state surveyors at the parent location if requested.

(2) Locations that do not meet these criteria:

(A) Will not be approved as a ~~satellite office~~multiple location; and

(B) Must obtain a separate license.

Appendix A. Tables for Rules for Hospice in Arkansas

Link:

<https://CodeOfARRules.arkansas.gov/docs/CARCodeAppendices/Appendices/293/20CARpt.47Appendix.pdf>

State of Arkansas
95th General Assembly
Regular Session, 2025

A Bill

SENATE BILL 137

By: Senator J. Boyd
By: Representative Achor

For An Act To Be Entitled

AN ACT TO PERMIT HEALTHCARE PROVIDERS TO MAINTAIN
MEDICAL RECORDS IN AN ELECTRONIC FORMAT; AND FOR
OTHER PURPOSES.

Subtitle

TO PERMIT HEALTHCARE PROVIDERS TO
MAINTAIN MEDICAL RECORDS IN AN
ELECTRONIC FORMAT.

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

SECTION 1. Arkansas Code Title 20, Chapter 9, Subchapter 1, is amended
to add an additional section to read as follows:

20-9-106. Electronic medical records – Definitions.

(a) As used in this section:

(1) "Healthcare provider" means:

(A) An individual who is licensed, certified, or otherwise
authorized by a licensing authority of this state to administer healthcare
services in the ordinary course of his or her business or practice; or

(B) A healthcare facility including without limitation a
hospital, pharmacy, long-term care facility, office of a healthcare
professional, or a hospice facility;

(2) "Medical record" means a patient's health record, including
without limitation evaluations, diagnoses, prognoses, laboratory reports, X-
rays, prescriptions, and other technical information used in assessing the
patient's condition, or the pertinent portion of the record relating to a
specific condition or a summary of the record; and



1 (3) "Patient" means a person who has received healthcare
2 services from a healthcare provider.

3 (b) Notwithstanding any other provision of the law to the contrary, a
4 healthcare provider may, in its sole discretion, create, maintain, transmit,
5 receive, and store medical records in an electronic format and may, in its
6 sole discretion, temporarily or permanently convert records into an
7 electronic format.

8 (c)(1) A healthcare provider is not required to maintain separate
9 tangible copies of electronically stored medical records.

10 (2) However, the healthcare provider shall maintain
11 electronically stored medical records in a legible and retrievable form,
12 including adequate data backup.

13 (d) This section is subject to all applicable federal laws governing
14 the security and confidentiality of a patient's personal health information.

15 (e) A tangible copy of a medical record reproduced from an
16 electronically stored record shall be considered an original for purposes of
17 providing copies to patients or other authorized parties and for introduction
18 of the medical record into evidence in administrative or court proceedings.

19 (f)(1) Except as provided otherwise under federal law, upon receiving
20 a request for a copy of a medical record from a patient or an authorized
21 person, a healthcare provider shall provide copies of the medical record in
22 either tangible or electronically stored form.

23 (2) Except as provided otherwise under federal law, if a
24 healthcare provider is audited by a health benefit plan, a pharmacy benefit
25 manager, or a third-party entity involved in health benefits, the auditor
26 shall accept an electronic version of the medical record in lieu of a
27 physical medical record.

28 (g) This section applies to psychiatric, psychological, or other
29 mental health medical records of a patient.

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32 **APPROVED: 2/25/25**
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35
36

State of Arkansas

As Engrossed: S3/17/25

95th General Assembly

A Bill

Regular Session, 2025

SENATE BILL 322

By: Senator J. Bryant

By: Representative Pilkington

For An Act To Be Entitled

AN ACT TO AMEND THE LAW CONCERNING CONSTRUCTION AND
DEVELOPMENT; TO ALLOW THIRD PARTIES TO PERFORM PLAN
REVIEWS AND SITE INSPECTIONS; AND FOR OTHER PURPOSES.

Subtitle

TO AMEND THE LAW CONCERNING CONSTRUCTION
AND DEVELOPMENT; AND TO ALLOW THIRD
PARTIES TO PERFORM PLAN REVIEWS AND SITE
INSPECTIONS.

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

SECTION 1. Arkansas Code § 14-1-503 is amended to read as follows:

14-1-503. Definitions.

As used in this subchapter:

*(1) "Applicant" means a person that submits a request for permit
or a person designated to act on the applicant's behalf in submitting a
request for permit;*

*(2) "Local governing body" means a group of persons elected or
appointed to make decisions for or recommendations to one (1) or more local
governments;*

*(3) "Local government" means a municipality, county, or other
political subdivision of this state;*

*(4) "Local government official" means an employee of a local
government who is lawfully authorized to issue a permit;*

*(5) "Person" means an individual, corporation, limited liability
company, partnership, association, trust, or other entity or organization*



1 that can sue or be sued; ~~and~~

2 (6) "Private professional provider" means one (1) of the
3 following who is not an employee of or otherwise affiliated with the person
4 engaged in the construction project to be reviewed or inspected:

5 (A) A professional engineer as defined in § 17-30-101;

6 (B) A registered architect as defined in § 17-15-102; or

7 (C) A person licensed, certified, or registered by the
8 applicable agency or body to conduct the type of plan review or inspection
9 covered under this section;

10 (7) "Regulatory fee" means payments, whether designated as
11 permit fees, application fees, or by another name, that are required by the
12 local government to accept a request for permit or request for inspection;

13 (8)(A) "Regulatory requirements" means the requirements
14 reasonably determined by the local government to be necessary for approval of
15 plans, permits, or applications under this subchapter.

16 (B) "Regulatory requirements" includes:

17 (i) The Arkansas Fire Prevention Code as adopted by
18 the State Fire Marshal;

19 (ii) The state plumbing code;

20 (iii) The fuel gas code;

21 (iv) The plumbing law under § 17-38-301 et seq.;

22 (v) Any locally adopted ordinances and amendments to
23 the ordinances;

24 (vi) Development, utility, and subdivision
25 regulations;

26 (vii) Applicable zoning ordinances and conditions;

27 (viii) Design standards; and

28 (ix) Other state and local laws, rules, and
29 ordinances applicable to the application in question;

30 (9) "Request for inspection" means a request for an inspection
31 of improvements related to a residential, multifamily, commercial, or
32 industrial development or subdivision within the jurisdiction of a local
33 government; and

34 (10) "Request for permit" means a request for a local government
35 official's approval of a permit related to the development of a residential,
36 multifamily, commercial, or industrial improvement within the jurisdiction of

1 a local government.

2
3 SECTION 2. Arkansas Code § 14-1-504 is amended to read as follows:
4 14-1-504. Request for permit – Time period for approval or denial –
5 Notice of denial required.

6 (a)(1) No later than five (5) business days after receipt of a request
7 for permit, a local government official shall notify the applicant
8 electronically or in writing as to whether the request for permit meets the
9 regulatory requirements of a complete application under § 14-1-505.

10 (2)(A) Time spent by the local government official determining
11 whether the request for permit is complete shall count toward the sixty-day
12 time for review or inspection under this section.

13 (B) If a local government official determines that the
14 request for permit is incomplete, the local government official shall follow
15 the procedure under § 14-1-505.

16 (b)(1) Upon notification to an applicant under subdivision (a)(1) of
17 this section that a complete application has been accepted, the local
18 government official shall also notify the applicant electronically or in
19 writing as to whether the personnel employed or contracted by the local
20 government will be able to provide action by plan review for approval,
21 denial, or request for revisions on the request for permit within sixty (60)
22 days.

23 (2)(A)(i) If the local government official determines that the
24 personnel employed or contracted by the local government cannot provide
25 action by plan review within the time required under subdivision (b)(1) of
26 this section, the applicant may request that the local government retain a
27 private professional provider, at the local government's expense, to provide
28 the required plan review under this subchapter.

29 (ii) The request under subdivision (b)(2)(A)(i) of
30 this section shall be made electronically or in writing within three (3)
31 business days upon receipt of notification from the local government
32 official.

33 (B)(i) If the local government official determines that
34 the personnel employed or contracted by the local government can provide
35 action by plan review within the time required under subdivision (b)(1) of
36 this section, the applicant may retain a private professional provider to

1 provide the required plan review under this subchapter.

2 (ii) If the applicant does not notify the local
3 government official electronically or in writing within three (3) business
4 days of receipt of notification from the local government official, the plan
5 review will commence by the personnel employed or contracted by the local
6 government.

7 (C) If the applicant elects to retain the services of a
8 private professional provider, the applicant shall bear the full
9 responsibility of expense of the private professional provider and any
10 regulatory fees associated with the request for permit.

11 (D) An applicant may provide notice of intent to elect to
12 retain the services of a private professional provider at the time of
13 application for a request for permit.

14 (c)(1) A local government official shall act by approval, denial, or a
15 request for revision of an applicant's request for permit within sixty (60)
16 days from the date the local government official receives the request for
17 permit.

18 (2) If the local government official does not approve, deny, or
19 request a revision of an applicant's request for permit within sixty (60)
20 days as required under subdivision ~~(a)(1)~~ (c)(1) of this section, the:

21 (A) ~~request~~ Request for permit is automatically approved;
22 and

23 (B) Local government official shall refund all regulatory
24 fees for the request for permit.

25 (3) A local government official shall not deny an applicant's
26 request for permit if the request for permit complies with and includes the
27 requirements related to the request for permit imposed by the local governing
28 body.

29 (4)(A) Except as provided in subdivision (c)(4)(B) of this
30 section, the local governing body may limit the:

31 (i) Scope of a request for permit; and

32 (ii) Areas of the site to which the request for
33 permit may apply.

34 (B) The local governing body shall allow the applicant to
35 begin work on the project if a portion of the initial phase of work is
36 compliant with applicable codes, laws, and rules.

1 ~~(b)~~(d) A local government official shall not impose additional
2 requirements related to the request for permit if the request for permit is
3 automatically approved under subdivision ~~(a)(2)~~ (c)(2) of this section.

4 ~~(e)~~(e) The automatic approval of a permit under subdivision ~~(a)(2)~~
5 (c)(2) of this section shall not authorize the permit holder to violate a:

- 6 (1) Federal law or rule;
7 (2) State law or rule; or
8 (3) Local ordinance or rule.

9 ~~(d)~~(f) Unless the applicant waives the automatic approval under
10 subdivision ~~(a)(2)~~ (c)(2) of this section, a local government official may
11 refuse to accept a request for permit submitted by a person who previously
12 submitted a request for permit that has not yet been approved or denied.

13 ~~(e)~~(g)(1) The time period for approval or denial of a request for
14 permit shall be extended to accommodate a time period prescribed by state
15 statute, federal law, or court order that prohibits a local government
16 official from approving or denying a request for permit within sixty (60)
17 days.

18 (2) A local government shall provide an applicant written notice
19 stating the reasons for the extension.

20 (3) The time period for approval or denial shall be extended
21 sixty (60) days from the date of compliance as required by the state statute,
22 federal law, or court order.

23 (4) A delay in action on a request for permit that is caused by
24 the fault of the applicant shall not count toward the sixty-day period for
25 action by approval, denial, or request for revisions on a request for permit.

26 ~~(f)~~(h) Upon consent of the applicant, a local government official may
27 extend the time period for approval or denial of a request for permit by
28 providing the applicant written notice stating the reasons for the extension.

29 ~~(g)~~(i) If a local government official denies a request for permit, the
30 local government official shall provide the applicant written or electronic
31 notice of the denial stating the reasons the request for permit was denied.

32
33 SECTION 3. Arkansas Code Title 14, Chapter 1, Subchapter 5, is amended
34 to add additional sections to read as follows:

35 14-1-506. Plan review for request for permit.

36 (a) A plan review conducted by a private professional provider shall

1 be no less extensive than a plan review conducted by a local government
2 official.

3 (b)(1) A private professional provider performing a plan review under
4 this section shall review the plans to determine compliance with all
5 applicable regulatory requirements.

6 (2) Upon determining that the plans reviewed comply with the
7 applicable regulatory requirements, the private professional provider shall
8 prepare an affidavit or affidavits certifying under oath that the following
9 is true and correct to the best of the private professional provider's
10 knowledge and belief and in accordance with the applicable professional
11 standard of care:

12 (A) That the plans were reviewed by the affiant who is
13 authorized to perform the plan review under this section and who holds the
14 appropriate license or certifications and insurance coverage required under
15 this subchapter;

16 (B) That a determination has been made that the plan is in
17 compliance; and

18 (C) That a determination has been made that plans
19 submitted for the plan review are in conformity with plans previously
20 submitted or approved by the local government in the plan submittal process.

21 (c) The private professional provider shall be authorized to perform a
22 plan review for a request for permit required by the local government,
23 including without limitation plan review for:

24 (1) Civil plans;

25 (2) Construction plans; and

26 (3) Plumbing plans if allowed by the Department of Health.

27 (d)(1)(A) An applicant using a private professional provider shall
28 submit a copy of the private professional provider's plan review report to a
29 local government official within five (5) days of completion of the plan
30 review report.

31 (B) A plan review report under subdivision (d)(1)(A) of
32 this section shall include without limitation the following:

33 (i) The affidavit of the private professional
34 provider required under subdivision (b)(2) of this section; and

35 (ii) Any documents reasonably required by the local
36 government official and any other documents reasonably necessary to determine

1 that the applicant has secured all other governmental approvals required by
2 law.

3 (2)(A) No more than ten (10) business days after receipt of a
4 plan review report from the private professional provider, the local
5 government official shall issue the requested permit or provide written
6 notice to the applicant identifying the specific plan features that do not
7 comply with the applicable regulatory requirements as well as the specific
8 code chapters and sections of the regulatory requirements.

9 (B) If the local government official does not provide a
10 written notice of the plan deficiencies with specific code references to the
11 regulatory requirements not met within the prescribed ten-day period, the:

12 (i) Request for permit shall be deemed approved as a
13 matter of law; and

14 (ii) Permit shall be issued by the local government
15 official on the next business day.

16 (3)(A) If the local government official provides a written
17 notice of plan deficiencies to the applicant within the prescribed ten-day
18 period, the ten-day period shall be tolled pending resolution of the matter.

19 (B) To resolve the plan deficiencies, the applicant may:

20 (i) Dispute the plan deficiencies under this
21 subchapter; or

22 (ii) Submit revisions to correct the plan
23 deficiencies.

24 (4)(A) If the applicant submits revisions to address the plan
25 deficiencies previously identified, the local government official shall have
26 the remainder of the tolled ten-day period plus an additional five (5)
27 business days to issue the requested permit or to provide a second written
28 notice to the applicant stating which plan features remain in noncompliance
29 with the applicable regulatory requirements, with specific reference to the
30 relevant code chapters and sections of the regulatory requirements.

31 (B) If the local government official does not provide the
32 second written notice under subdivision (4)(A) of this section within the
33 prescribed time, the permit shall be issued by the local government official
34 on the next business day.

35 (C) If the revisions required to address the plan
36 deficiencies or any additional revisions submitted by the applicant require

1 that new governmental approvals be obtained, the applicant shall obtain the
2 approvals before a new plan report can be submitted.

3 (5)(A) If the local government official provides a second
4 written notice of plan deficiencies under subdivision (4)(A) of this section
5 to the applicant within the prescribed time, the applicant may:

6 (i) Dispute the plan deficiencies under this
7 subchapter; or

8 (ii) Submit additional revisions to correct the plan
9 deficiencies.

10 (B) For all revisions submitted after the first revision,
11 the local government official shall have an additional five (5) business days
12 to issue the requested permit or to provide a written notice to the applicant
13 stating which plan features remain in noncompliance with the applicable
14 regulatory requirements, with specific reference to the relevant code
15 chapters and sections.

16 (6)(A) If the local government official and the private
17 professional provider are unable to resolve a dispute on matters concerning
18 any ordinance, regulation, or policy of the local government, the matter
19 shall be referred to the local governing body, which shall consider the
20 matter by whichever occurs first:

21 (i) The next scheduled meeting of the local
22 governing body; or

23 (ii) Within thirty (30) days from the date the
24 matter is referred.

25 (B) If the local government official and the private
26 professional provider are unable to resolve a dispute on matters concerning
27 state law or state adopted building codes, the matter shall be referred to
28 the Department of Labor and Licensing, which shall consider the matter by
29 whichever occurs first:

30 (i) The next scheduled meeting of the local
31 governing body; or

32 (ii) Within thirty (30) days from the date the
33 matter is referred.

34 (e) The Department of Labor and Licensing may promulgate rules to
35 implement this section.

36

14-1-507. Request for inspection by private professional provider.

(a)(1) An applicant making a request for inspection may retain a private professional provider to conduct the requested inspection at the expense of the applicant.

(2)(A) At the time the request for inspection is made to a local government official or at any time thereafter, the applicant shall include electronic or written notice of the intent to retain a private professional provider to complete a required inspection.

(B) The notice shall include the date, time, and location of the inspection to be completed.

(C) A local government official may be present during the inspection.

(3) If the applicant elects to retain the services of a private professional provider, the applicant shall bear the full responsibility of expense of the private professional provider and any regulatory fees associated with the request for inspection.

(b)(1) Upon completion of the inspection by the private professional provider, the private professional provider shall submit a copy of his or her inspection report to the local government official.

(2) The local government official shall accept the inspection and inspection report of the private professional provider without further inspection or approval by the personnel employed or contracted by the local government unless the local government official has notified the private professional provider, within one (1) business day after the submission of the inspection report, that the local government official finds the report incomplete or the inspection inadequate and has provided the private professional provider with a written description of the deficiencies and specific regulatory requirements that have not been adequately addressed.

(c) A local government may impose reasonable restrictions on the continuation of work that would hide, obscure, or make it impossible to inspect work subject to the inspection until the inspection report has been approved by the local government official.

(d) The private professional provider may perform an inspection or a review required by a local government, including without limitation:

(1) Inspections for:

(A) Footings, foundations, concrete slabs, sidewalks, and

1 streets;

2 (B) Framing;

3 (C) Electrical components;

4 (D) Plumbing;

5 (E) Heating ventilation and air conditioning;

6 (F) Drainage; and

7 (G) Utilities;

8 (2) All other inspections not listed under subdivision (d)(1) of
9 this section that are necessary or required to determine compliance with
10 applicable regulatory requirements; and

11 (3) Review for the issuance of a building permit or inspections
12 for a certificate of occupancy issued by a local government.

13 (e) This subchapter does not authorize a private professional provider
14 to issue a certificate of occupancy or building permit.

15
16 14-1-508. Fees.

17 (a) A local government that imposes regulatory fees or regulatory
18 requirements within its jurisdiction shall establish and make available a
19 schedule of the regulatory fees.

20 (b) The amount of a regulatory fee shall approximate the reasonable
21 cost of the actual regulatory activity performed by the local government.

22
23 14-1-509. Exemptions.

24 (a) This subchapter does not limit a public or private right of action
25 designed to provide protection, rights, or remedies for consumers.

26 (b) This subchapter does not apply to:

27 (1) Hospitals;

28 (2) Ambulatory healthcare centers;

29 (3) Nursing homes;

30 (4) Jails;

31 (5) Penal institutions;

32 (6) Airports;

33 (7) Buildings or structures that affect national or state
34 homeland security; or

35 (8)(A) A building defined as a high-rise building in the
36 Arkansas Fire Prevention Code.

1 (B) An interior tenant build-out project within a high-
2 rise building is not exempt from this subchapter.

3
4 14-1-510. Stop-work orders.

5 (a) If a local government official responsible for building code
6 enforcement determines that a project does not comply with the applicable
7 regulatory requirements, the local government official may:

8 (1) Deny the permit or request for a certificate of occupancy or
9 certificate of completion, as appropriate; or

10 (2) Issue a stop-work order for the project or any portion of
11 the project as provided by law after:

12 (A) Providing notice to one (1) of the following
13 individuals:

14 (i) The owner;

15 (ii) The private professional provider of record; or

16 (iii) The contractor of record;

17 (B) Posting a copy of the order on the site of the
18 project; and

19 (C) Providing the opportunity to remedy the violation
20 within the time set forth in the notice.

21 (b) A local government official shall be available to meet with the
22 private professional provider within two (2) business days after issuing a
23 stop-work order under subdivision (a)(2) of this section to resolve any
24 dispute after issuing a stop-work order or providing notice to the applicant
25 denying:

26 (1) A permit;

27 (2) A request for a certificate of occupancy; or

28 (3) A certificate of completion.

29 (c) If the local government official and the private professional
30 provider are unable to resolve the dispute or meet within the time required
31 under subsection (b) of this section, the matter shall be referred to the
32 local governing body, which shall consider the matter by whichever occurs
33 first:

34 (1) The next scheduled meeting of the local governing body; or

35 (2) Within thirty (30) days from the date the matter is
36 referred.

14-1-511. Authority of local government.

(a) A local government, local government official, member of local government building code enforcement personnel, and agents of the local government are immune from liability to any person or party for any action or inaction by an owner of a building or by a private professional provider or his or her authorized representative in connection with plan review or inspection services by private professional providers as provided under this subchapter.

(b) A local government may establish a list of private professional providers working within the jurisdiction of the local government.

(c) A local government may establish requirements regarding certification and licensure for private professional providers that equate to the certifications and licensure requirements required for personnel employed or contracted by the local government to conduct plan reviews and inspections as may be applicable to the particular type of plan review or inspection.

14-1-512. Liability of private professional providers.

(a) When performing plan review or inspection services under this subchapter, a private professional provider is subject to the disciplinary guidelines of the applicable professional licensing board with jurisdiction over the private professional provider's license or certification, as applicable.

(b) Any complaint processing, investigation, or disciplinary action that arises from a private professional provider's performance of plan review or inspection services shall be conducted by the applicable professional licensing board unless the action constitutes a violation of a local ordinance or law.

(c) Except as provided under the disciplinary rules of the applicable professional licensing board with jurisdiction over the private professional provider's license or certification, a local government official may decline to accept a plan review or an inspection report submitted by a private professional provider who has submitted multiple reports that required revisions due to:

(1) Negligence;

(2) Noncompliance; or

1 (3) Deficiencies.

2 (d) A private professional provider providing plan review or
3 inspection services under this subchapter shall secure and maintain insurance
4 coverage under an errors and omissions policy for professional liability
5 insurance.

6 (e) The limits of the professional liability insurance under this
7 section shall be not less than:

8 (1) One million dollars (\$1,000,000) per claim and one million
9 dollars (\$1,000,000) in aggregate coverage for any project with a
10 construction cost of less than five million dollars (\$5,000,000); or

11 (2) Two million dollars (\$2,000,000) per claim and two million
12 dollars (\$2,000,000) in aggregate coverage for any project with a
13 construction cost of five million dollars (\$5,000,000) or more.

14 (f)(1) Professional liability insurance under this section may be a
15 practice policy or project-specific coverage.

16 (2) If the professional liability insurance under this section
17 is a practice policy, it shall contain prior-acts coverage for the private
18 professional provider.

19 (3) If the professional liability insurance under this section
20 is project-specific, it shall continue in effect for two (2) years following
21 the issuance of the certificate of final completion for the project.

22 (g) An applicant using a private professional provider shall verify
23 compliance with the insurance requirements of this section and provide the
24 information to the local government official.

25
26 /s/J. Bryant
27

28
29 APPROVED: 4/14/25
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