

Regulations of Connecticut State Agencies

TITLE 19a. Public Health and Well-Being

Agency

Department of Public Health

Subject

Personal Data

Inclusive Sections

§§ 19a-2a-1—19a-2a-29

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Personal Data

Sec. 19a-2a-1. Definitions

In addition to the definitions in Section 4-190 of Connecticut General Statutes, as used in sections 19a-2a-1 through 19a-2a-23 of the regulations of Connecticut State Agencies:

(1) “Appointing authority” means a board, commission, officer, commissioner, person or group of persons having the power to make appointments by virtue of a statute or by lawfully delegated authority.

(2) “Category of personal data” means the classifications of personal information set forth in subsection (9) of Section 4-190 of the Connecticut General Statutes.

(3) “Commissioner” means the commissioner of public health.

(4) “Department” means the department of public health.

(5) “Other data” means any information which because of name, identifying number, mark or description can be readily associated with a particular person.

(6) “Patient” or “client” means any individual who is receiving treatment or services or who has received treatment or services in any facility operated by the department either directly or under contract, or who has requested information regarding treatment or services. State employees receiving services from the Employee Assistance Program are considered clients of the department.

(Adopted effective August 24, 1995)

Sec. 19a-2a-2. Business office system

(a) General nature and purpose

(1) Location. The business office system is located at 150 Washington Street, Hartford, Connecticut.

(2) Format. Personal data is stored in the business office system in both automated and manual forms.

(3) Purpose. The purpose of the business office system is to provide relevant personal data needed for the department’s accounting and budgeting transactions and records.

(4) Official responsible. The chief administrative officer of the department is located at 150 Washington Street, Hartford, CT and is responsible for the business office system. Requests for disclosure or amendment of the records in the system should be directed to this official.

(5) Routine sources. Personal data in the business office system is routinely obtained from:

(A) contracts;

(B) budgets; and

(C) travel vouchers.

(6) Legal authority. Collection, maintenance and use of personal data in the business office system is authorized by Sections 19a-2a and 19a-32 of the Connecticut General Statutes.

(b) Categories

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(1) The categories of personal data maintained by the business office system are:

- (A) resumes;
- (B) signature file forms;
- (C) payroll schedules; and
- (D) travel authorization forms.

(2) The categories of other data maintained by the business office are:

- (A) social security numbers; and
- (B) addresses.

(3) The categories of persons on whom records are maintained are:

- (A) employees; and
- (B) individuals on contract to the department.

(c) **Uses**

(1) Routine uses

(A) Users. The business office system is used by:

- (i) business office accountants;
- (ii) the fiscal officer; and
- (iii) the business manager.

(B) Purpose. The business office system is used for:

- (i) budget purposes;
 - (ii) accounting;
 - (iii) ensuring up-to-date insurance is on hand when reimbursing for employees' travel;
- and

- (iv) payments for contractual services.

(2) Retention. Records for each personal data system are maintained in accordance with schedules prepared by the Connecticut State Library, Department of Public Records Administration and records retention schedule as approved by the Public Records Administrator as authorized by section 11-8a of the Connecticut General Statutes. Retention schedules shall be maintained on file at the office of the official responsible for the data system and may be examined during normal business hours.

(Adopted effective August 24, 1995)

Sec. 19a-2a-3. Children with special health care needs system

(a) **General nature and purpose**

(1) Location. The children with special health care needs system is located at 999 Asylum Avenue, Hartford, Connecticut.

(2) Format. Personal data on children with special health care needs is stored in manual form.

(3) Purpose. The purpose of the special health care needs system is to provide the program personnel with data regarding the children who receive service.

(4) Official responsible. The director of child and adolescent health division of the department is located at 999 Asylum Avenue, Hartford, CT and is responsible for the

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children with special health care needs system. Requests for disclosure or amendment of the records in the system should be directed to this official.

(5) Routine sources. Personal data in the children with special health care needs system are received from:

- (A) the referring person or agency;
- (B) the family of the child; and
- (C) providers of service to the child.

(6) Legal authority. The legal authority for the children with special health care needs system is Connecticut General Statutes, Sections 19a-48 through 19a-55, 19a-59, and 19a-61.

(b) Categories

(1) The categories of personal data maintained in the children with special health care needs system include, but are not necessarily limited to:

- (A) name of child;
- (B) names of parents or guardians and siblings;
- (C) address of child;
- (D) birthdate of child;
- (E) race of child;
- (F) sex of child;
- (G) family income;
- (H) employers of parents or guardians;
- (I) family medical insurance information;
- (J) medical information regarding the child; and
- (K) information regarding services provided for the child, including amount paid on fee-for-service care.

(2) There are no categories of other data maintained in the special health care needs system.

(3) Records are maintained on children referred to the program for services.

(c) Uses

(1) Routine uses

- (A) Users. The children with special health care needs system is used by program staff.
- (B) Purpose. The children with special health care needs system is used to:
 - (i) determine eligibility,
 - (ii) provide case management services, and
 - (iii) prepare statistical reports.

(2) Retention. Records for each personal data system are maintained in accordance with schedules prepared by the Connecticut State Library, Department of Public Records Administration and records retention schedule as approved by the Public Records Administrator as authorized by section 11-8a of the Connecticut General Statutes. Retention schedules shall be maintained on file at the office of the official responsible for the data

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system and may be examined during normal business hours.

(Adopted effective August 24, 1995)

Sec. 19a-2a-4. Division of chronic disease and injury prevention system

(a) General nature and purpose

(1) Location. The division of chronic disease and injury prevention system is located at 141 Washington Street, Hartford, Connecticut.

(2) Format. Personal data is stored in the division of chronic disease and injury prevention system in both automated and manual forms.

(3) Purpose. Working directly and with citizens through grants awarded to local health departments and other community agencies, the division provides chronic disease and injury prevention and early detection programs for at-risk populations.

(4) Official responsible. The director, division of chronic disease and injury prevention, is located at 141 Washington Street, Hartford, CT and is responsible for the division of chronic disease and injury prevention data system. Requests for disclosure or amendment of the records in the system should be directed to this official.

(5) Routine sources. Personal data in the division of chronic disease and injury prevention data system is routinely obtained from:

- (A) division staff;
- (B) staff from other agencies; and
- (C) contractors.

(6) Legal authority. Collection, maintenance, and use of personal data in the division of chronic disease and injury prevention data system is authorized by Connecticut General Statutes Section 19a-2a.

(b) Categories

(1) The categories of personal data maintained by the division of chronic disease and injury prevention health system are:

- (A) names, addresses, phone numbers, age, sex; and
- (B) certain medical information (e.g., blood pressure measurements, results of mammograms for program participants).

(2) There are no categories of other data maintained in the chronic disease and injury prevention data system.

(3) The categories of persons on whom records are maintained are contractors' program participants in:

- (A) blood pressure screening programs;
- (B) cholesterol screening programs;
- (C) exercise programs;
- (D) nutrition programs;
- (F) diabetes control programs;
- (G) breast and cervical cancer screenings;
- (H) smoking cessation programs; and

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(I) violence and injury control programs.

(c) **Uses**

(1) Routine uses

(A) Users. The division of chronic disease and injury prevention system is used by:

- (i) division of chronic disease staff; and
- (ii) federal and state funding agency staff.

(B) Purpose. The system is used to:

- (i) monitor contracts;
- (ii) evaluate program effectiveness;
- (iii) manage the contract process;
- (iv) track participants requiring follow-up; and
- (v) report to federal funding agencies.

(2) Retention. Records for each personal data system are maintained in accordance with schedules prepared by the Connecticut State Library, Department of Public Records Administration and records retention schedule as approved by the Public Records Administrator as authorized by section 11-8a of the Connecticut General Statutes. Retention schedules shall be maintained on file at the office of the official responsible for the data system and may be examined during normal business hours.

(Adopted effective August 24, 1995)

Sec. 19a-2a-5. Community nursing and day care division data system

(a) **General nature and purpose**

(1) Location. The community nursing and day care division data system is located at 20 Trinity Street, Hartford, Connecticut.

(2) Format. Personal data in the community nursing and day care division is stored in both automated and manual forms.

(3) Purpose. The purpose of this personal data system is to provide information required in order to evaluate an application for licensure of a clinic, a free standing family planning and abortion clinic, a child health clinic, a school-based infirmary, a child day care center, a group day care home, a family day care center, and for the division to grant approval for the administration of certain medications by school personnel.

(4) Official responsible. The director, community nursing and day care division, is located at 20 Trinity St., Hartford, Connecticut, and is responsible for the community nursing and day care division system. Requests for disclosure or amendment of the records in the system should be directed to this official.

(5) Routine sources. Personal data in the community nursing and day care division data system is obtained from:

- (A) applicants for licensure;
- (B) their employees, and clients.

(6) Legal authority. Collection, maintenance and use of personal data in the community nursing and day care division data system is authorized by Connecticut General Statutes,

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sections:

- (A) 10-212a;
- (B) 19a-80;
- (C) 19a-87b; and
- (D) 19a-491.

(b) **Categories**

(1) The categories of personal data maintained by the community nursing and day care division data system include, but are not necessarily limited to:

- (A) applicants' names, addresses, education, training, and experience; and
- (B) the names, addresses, education, training and experience of staff working in licensed facilities.

(2) The categories of other data maintained by the community nursing and day care division data system are data regarding the organizational structure associated with the ownership of licensed facilities.

(3) The categories of persons on whom records are maintained are:

- (A) clients who have made or have cause to make complaints;
- (B) children who have made or have cause to make complaints; and
- (C) individuals employed in regulated positions.

(c) **Uses**

(1) Routine uses

(A) Users. The community nursing and day care division data system is used by department employees assigned to carry out regulatory programs.

(B) Purpose. The purpose of the community nursing and day care division data system is to verify compliance or noncompliance by providers with requirements for licensure or grants.

(2) Retention. Records for each personal data system are maintained in accordance with schedules prepared by the Connecticut State Library, Department of Public Records Administration and records retention schedule as approved by the Public Records Administrator as authorized by section 11-8a of the Connecticut General Statutes. Retention schedules shall be maintained on file at the office of the official responsible for the data system and may be examined during normal business hours.

(Adopted effective August 24, 1995)

Sec. 19a-2a-6. Environmental health data system

(a) **General nature and purpose**

(1) Location. The environmental health data system is located at 21 Grand Street, Hartford, Connecticut.

(2) Format. Personal data is stored in the environmental health data system in both automated and manual forms.

(3) Purpose. The purpose of the environmental health data system is to:

- (A) document reduced morbidity and mortality; and

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(B) improve living conditions for state residents as a result of:

- (i) educational programs;
- (ii) regulatory programs; and
- (iii) passive programs that address hazards through alteration of the environment.

(4) Official responsible. The bureau chief of the health promotion bureau is located at 21 Grand Street, Hartford, Connecticut, and is responsible for the environmental health data system. Requests for disclosure or amendment of the records in the system should be directed to this official.

(5) Routine sources. Personal data in the environmental health data system is routinely obtained from:

- (A) professional licenses;
- (B) professional registrations;
- (C) professional certifications;
- (D) environmental inspection results; and
- (E) occupational exposure results.

(6) Legal authority. Collection, maintenance and use of personal data in the environmental health data system is authorized by Connecticut General Statutes, sections:

- (A) 19a-110 through 19a-111d;
- (B) 19a-421;
- (C) 19a-426; and
- (D) 20-435 through 20-439.

(b) Categories

(1) The categories of personal data maintained by the environmental health data system are:

- (A) educational;
- (B) employment history;
- (C) inspectional;
- (D) training and work experience; and
- (E) medical.

(2) The category of other data maintained by the environmental data system is business records.

(3) The categories of persons on whom records are maintained are:

- (A) applicants for professional registration, certification or licensure; and
- (B) persons with high blood lead levels.

(c) Uses

(1) Routine uses

(A) Users. The environmental health data system is used by department staff.

(B) Purpose. The environmental health data system is used for:

- (i) verification of educational credentials;
- (ii) verification of training or work credentials;
- (iii) disease and environmental surveillance; and

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(iv) monitoring of conformance to regulations and statutes.

(2) Retention. Records for each personal data system are maintained in accordance with schedules prepared by the Connecticut State Library, Department of Public Records Administration and records retention schedule as approved by the Public Records Administrator as authorized by section 11-8a of the Connecticut General Statutes. Retention schedules shall be maintained on file at the office of the official responsible for the data system and may be examined during normal business hours.

(Adopted effective August 24, 1995)

Sec. 19a-2a-7. Office of emergency medical services data system

(a) General nature and purpose

(1) Location. The office of emergency medical services data system is located at 150 Washington Street, Hartford, Connecticut.

(2) Format. Personal data is stored in the office of emergency medical services data system in both automated and manual forms.

(3) Purpose. The purpose of the office of emergency medical services data system is to maintain documentation relating to technicians and instructors licensed and certified.

(4) Official responsible. The director of the office of emergency medical services is located at 150 Washington Street, Hartford, Connecticut, and is responsible for the office of emergency medical services data system. Requests for disclosure or amendment of the records in the system should be directed to this official.

(5) Routine sources. Personal data in the office of emergency medical services data system is routinely obtained from:

- (A) applicants seeking licensure or certification to provide emergency medical services;
- (B) applicants seeking licensure to provide ambulance or rescue services; and,
- (C) applicants' references.

(6) Legal authority. Collection, maintenance and use of personal data in the office emergency medical services data system is authorized by Connecticut General Statutes Sections 19a-178 through 19a-180.

(b) Categories

(1) The categories of personal data maintained by the office of emergency medical services data system include, but are not necessarily limited to:

- (A) name;
- (B) social security number;
- (C) address;
- (D) education and training; and
- (E) personal character references of applicant.

(2) There are no categories of other data maintained in the emergency medical services data system.

(3) The categories of persons on whom data is maintained are:

- (A) applicants for certification or licensure; and

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(B) persons certified or licensed by emergency medical services.

(c) **Uses**

(1) Routine uses

(A) Users. The office of emergency medical services data system is used by department employees assigned to carry out the office of emergency medical services regulatory programs.

(B) Purpose. The purpose of the office of emergency medical services data system is to maintain documentation relating to the qualification of applicants licensed and certified.

(2) Retention. Records for each personal data system are maintained in accordance with schedules prepared by the Connecticut State Library, Department of Public Records Administration and records retention schedule as approved by the Public Records Administrator as authorized by section 11-8a of the Connecticut General Statutes. Retention schedules shall be maintained on file at the office of the official responsible for the data system and may be examined during normal business hours.

(Adopted effective August 24, 1995)

Sec. 19a-2a-8. Vital records data system

(a) **General nature and purpose**

(1) Location. The vital records data system is located at 410 Capitol Avenue, Hartford, Connecticut.

(2) Format. Personal data in the vital records data system is maintained in both automated and manual forms.

(3) Purpose. The purpose of the vital records data system is to collect and preserve data concerning vital events occurring in Connecticut for:

(A) public health surveillance;

(B) health program development; and

(C) individuals seeking certified copies of vital records and other data as allowed by the Connecticut General Statutes.

(4) Official responsible. The registrar of vital records is located at 410 Capitol Avenue, Hartford, Connecticut, and is responsible for the supervision of the statewide vital records data collection system. Requests for disclosure or amendment of the records in the system should be directed to this official.

(5) Routine sources. Personal data in the vital records system is routinely obtained from:

(A) hospitals;

(B) funeral directors; and

(C) town clerks.

(6) Legal authority. The legal authority for the vital records data system is Connecticut General Statutes, sections:

(A) 19a-40;

(B) 7-47b;

(C) 7-48;

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(D) 7-60; and

(E) 7-62b.

(b) **Categories**

(1) The personal data in the vital records data system includes but is not necessarily limited to:

(A) name;

(B) date of birth;

(C) date of death;

(D) social security number;

(E) name of mother and father;

(F) address;

(G) race;

(H) sex;

(I) ethnicity;

(J) marital status;

(K) occupation;

(L) educational level;

(M) social and medical risk factors; and

(N) cause of death.

(2) The vital records system consists of the vital records of people who are born, marry, or die in Connecticut. The vital records system also includes records of persons born in another country and adopted by residents of Connecticut.

(c) **Uses**

(1) Routine uses

(A) Users. Routine users include:

(i) genealogical researchers;

(ii) state agencies;

(iii) the federal government;

(iv) researchers; and

(v) registrants.

(B) Purpose. The department uses the vital records data system for:

(i) community-based planning;

(ii) statistical research regarding public health surveillance; and

(iii) assisting the United States Census Bureau and the Department of Public Health in making population estimates.

(2) Retention. Records in each personal data system are maintained in accordance with retention schedules established or approved by the Connecticut State Library, Office of the Public Records Administrator, pursuant to section 11-8a of the Connecticut General Statutes. Retention schedules shall be maintained on file at the office of the official responsible for the data system and may be examined during normal business hours.

(Adopted effective August 24, 1995; Amended January 3, 2011)

Sec. 19a-2a-9. Long term care data system

(a) General nature and purpose

(1) Location. The long term care data system is located at:

- (A) 150 Washington Street, Hartford, Connecticut; and
- (B) the State Data Center, 340 Capital Avenue, Hartford, Connecticut.

(2) Format. The data system is maintained in both automated and manual forms.

(3) Purpose. The purpose is to provide technical and analytical support for:

- (A) health program development;
- (B) policy analysis; and
- (C) program evaluation.

(4) Official responsible. The director of health research data analysis is located at 150 Washington Street, Hartford, Connecticut, and is the official responsible for the long term care data system. Requests for disclosure or amendment of the records in the system should be directed to this official.

(5) Routine sources. Personal data in the long term care data system is routinely obtained from:

- (A) nursing homes; and
- (B) the Connecticut State Department of Social Services.

(6) Legal authority. The legal authority for the long term care data system is regulations of Connecticut State Agencies, sections 19-6a-2, and 19-13-D8t(f) (3) (H).

(b) Categories

(1) The categories of personal data maintained in the long term care data system include, but are not necessarily limited to:

- (A) name of nursing home resident;
- (B) social security number;
- (C) sex;
- (D) year of birth;
- (E) race;
- (F) diagnosis and functional status;
- (G) admission and discharge dates; and
- (H) source of payment, medicaid number.

(2) The category of other data in the long term care data system is original town of residence.

(3) The category of people on whom records are maintained is nursing home residents.

(c) Uses

(1) Routine uses

(A) Users. The long term care data system is used by:

- (i) the Connecticut State Office of Policy and Management; and
- (ii) individuals or groups conducting research in long term health care.

(B) Purpose. The long term care data system is used for:

- (i) health planning; and

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(ii) program development and evaluation.

(2) Retention. Records for each personal data system are maintained in accordance with schedules prepared by the Connecticut State Library, Department of Public Records Administration and records retention schedule as approved by the Public Records Administrator as authorized by section 11-8a of the Connecticut General Statutes. Retention schedules shall be maintained on file at the office of the official responsible for the data system and may be examined during normal business hours.

(Adopted effective August 24, 1995)

Sec. 19a-2a-10. Connecticut tumor registry data system

(a) General nature and purpose

(1) Location. The connecticut tumor registry data system is located at 150 Washington Street, Hartford, Connecticut.

(2) Format. The tumor registry data system is maintained in both automated and manual forms.

(3) Purpose. The purpose is to provide:

- (A) cancer incidence and survival data for Connecticut;
- (B) data for cancer control program evaluation;
- (C) data for epidemiological studies of cancer in Connecticut; and
- (D) data for the National Cancer Institute.

(4) Official responsible. The director of the tumor registry is located at 150 Washington Street, Hartford, Connecticut, and is the official responsible for the tumor registry data system. Requests for disclosure or amendment of the records in the system should be directed to this official.

(5) Routine sources. Personal data in the tumor registry data system is routinely obtained from:

- (A) hospitals;
- (B) death certificates;
- (C) private pathology laboratories; and
- (D) reports from other state central cancer registries.

(6) Legal authority. The legal authority for the tumor registry data system is:

- (A) Connecticut General Statutes, sections 19a-72 and 19a-74; and
- (B) Regulations of Connecticut State Agencies, sections 19-6a-2, and 19a-73-1 through 19a-73-7.

(b) Categories

(1) The categories of personal data maintained in the tumor registry data system include, but are not necessarily limited to:

- (A) name;
- (B) social security number;
- (C) date of birth;
- (D) address;

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- (E) race;
- (F) ethnicity;
- (G) sex;
- (H) place of birth;
- (I) social and medical risk factors; and
- (J) health outcomes.
- (2) There are no categories of other data in the tumor registry data system.
- (3) The category of people on whom records are maintained is cancer patients.

(c) **Uses**

(1) Routine uses

(A) Users. The tumor registry data system is used by:

- (i) the department's Occupational Health Division;
- (ii) the department's Environmental Epidemiology Division;
- (iii) authorized researchers; and
- (iv) the National Cancer Institute.

(B) Purpose. The tumor registry data system is used for:

- (i) community-based health planning;
- (ii) program development;
- (iii) statistical research; and
- (iv) program compliance evaluation.

(2) Retention. Records for each personal data system are maintained in accordance with schedules prepared by the Connecticut State Library, Department of Public Records Administration and records retention schedule as approved by the Public Records Administrator as authorized by section 11-8a of the Connecticut General Statutes. Retention schedules shall be maintained on file at the office of the official responsible for the data system and may be examined during normal business hours.

(Adopted effective August 24, 1995)

Sec. 19a-2a-11. Healthy start data system

(a) **General nature and purpose**

(1) Location. The healthy start data system is located at 999 Asylum Avenue, Hartford, Connecticut.

(2) Format. Personal data is stored in the healthy start system in both automated and manual forms.

(3) Purpose. The purpose of the healthy start data system is to:

- (A) maintain data regarding the provision of services in the program;
- (B) monitor program accountability;
- (C) carry out program evaluation; and
- (D) apply for federal financial participation.

(4) Official responsible. The director, maternal and infant health division, is located at 999 Asylum Avenue, Hartford, Connecticut and is the official responsible for the healthy

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start data system. Requests for disclosure or amendment of the records in the system should be directed to this official.

(5) Routine sources. Personal data in the healthy start data system is routinely obtained from local grantees providing services to women, infants, and children.

(6) Legal authority. Collection, maintenance and use of personal data in the healthy start data system is authorized by the Connecticut General Statutes, Sections 19a-59 and 19a-59b.

(b) Categories

(1) The categories of personal data maintained by the healthy start data system include, but are not necessarily limited to:

- (A) name;
- (B) Medicaid eligibility status;
- (C) social security number;
- (D) town of residence;
- (E) Medicaid identification number;
- (F) race;
- (G) Hispanic origin information;
- (H) WIC eligibility status;
- (I) family size;
- (J) family income;
- (K) WIC identification number;
- (L) pregnancy outcome;
- (M) discharge information; and
- (N) medical information.

(2) There are no categories of other data collected.

(3) The category of persons on whom records are maintained is all healthy start program participants.

(c) Uses

(1) Routine uses

(A) Users. The healthy start data system is used by department program staff and grantee agencies.

(B) Purpose. The healthy start data system is used to:

- (i) determine eligibility;
- (ii) document individuals' case management and the liaison services provided;
- (iii) study the effect of prenatal care upon pregnancy outcome; and
- (iv) evaluate grantee performance.

(2) Retention. Records for each personal data system are maintained in accordance with schedules prepared by the Connecticut State Library, Department of Public Records Administration and records retention schedule as approved by the Public Records Administrator as authorized by section 11-8a of the Connecticut General Statutes. Retention schedules shall be maintained on file at the office of the official responsible for the data

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system and may be examined during normal business hours.

(Adopted effective August 24, 1995)

Sec. 19a-2a-12. Infectious disease epidemiology data system

(a) **General nature and purpose**

(1) Location. The infectious disease epidemiology data system is located at 21 Grand Street, Hartford, Connecticut.

(2) Format. Personal data is stored in the infectious disease epidemiology data system in both automated and manual forms.

(3) Purpose. The purpose of the infectious disease epidemiology data system is to:

(A) monitor the incidence and trends in diseases; and

(B) evaluate health education and health care programs.

(4) Official responsible. The bureau chief, of the bureau of health promotion, is located at 21 Grand Street, Hartford, Connecticut, and is responsible for the infectious disease epidemiology data system. Requests for disclosure or amendment of the records in the system should be directed to this official.

(5) Routine sources. The infectious disease epidemiology data system contains:

(A) data from reportable disease reports from health care providers and health care facilities including medical laboratories;

(B) reports from the Department of Correction,

(C) reports from schools;

(D) reports from local directors of health; and

(E) data from department health counselors and educators.

(6) Legal authority. Collection, maintenance and use of personal data in the infectious disease epidemiology data system data is authorized by:

(A) Connecticut General Statutes, Sections:

(i) 19a-215;

(ii) 19a-262; and

(B) The Regulations of Connecticut State Agencies:

(i) 19a-36-A1 through 19a-36-A6; and

(ii) 19a-36-A11.

(b) **Categories**

(1) The categories of personal data maintained by the infectious disease epidemiology data system include, but are not necessarily limited to:

(A) name;

(B) address;

(C) age;

(D) race;

(E) sex;

(F) occupation; and

(G) behaviors which put the individual at risk for infectious diseases.

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(2) There are no categories of other data collected for the infectious disease epidemiology data system.

(3) The category of persons on whom records are maintained is people with specific reportable diseases.

(c) **Uses**

(1) Routine uses

(A) Users. The infectious disease epidemiology data system is used by:

(i) the department; and

(ii) authorized researchers.

(B) Purpose. The infectious disease epidemiology data system is used for:

(i) disease surveillance; and

(ii) evaluation of health education and intervention programs.

(2) Retention. Records for each personal data system are maintained in accordance with schedules prepared by the Connecticut State Library, Department of Public Records Administration and records retention schedule as approved by the Public Records Administrator as authorized by section 11-8a of the Connecticut General Statutes. Retention schedules shall be maintained on file at the office of the official responsible for the data system and may be examined during normal business hours.

(Adopted effective August 24, 1995)

Sec. 19a-2a-13. Bureau of laboratory services data system

(a) **General nature and purpose**

(1) Location. The bureau of laboratory services data system is located at 10 Clinton Street, Hartford, Connecticut.

(2) Format. Personal data is stored in the bureau of laboratory services data system in both automated and manual forms.

(3) Purpose. The purpose of the bureau of laboratory services data system is to document and maintain laboratory analysis reports.

(4) Official responsible. The chief of the bureau of laboratory services is located at 10 Clinton Street, Hartford, Connecticut, and is the official responsible for the bureau of laboratory services data system. Requests for disclosure or amendment of the records in the system should be directed to this official.

(5) Routine sources. Personal data in the bureau of laboratory services data system is routinely obtained from:

(A) physicians;

(B) private and public laboratories;

(C) directors of health;

(D) sanitarians;

(E) various state agencies;

(F) the United States justice department;

(G) state and local police; and

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(H) other department bureaus and centers.

(6) Legal authority. Collection, maintenance and use of personal data in the bureau of laboratory services is authorized by Connecticut General Statutes, Sections:

(A) 19a-25 through 19a-30;

(B) 14-227a through 14-227c;

(C) 21a-274; and

(D) 21a-283.

(b) **Categories**

(1) The categories of personal data maintained by the bureau of laboratory services data system are laboratory analysis results associated with:

(A) patients;

(B) physicians;

(C) directors of health;

(D) other in-state laboratories;

(E) alleged criminal perpetrators; and

(F) principal parties in environmental and consumer protection actions.

(2) There are no categories of other data collected for the bureau of laboratory services data system.

(3) Categories of persons on whom records are maintained are:

(A) newborns,

(B) patients of medical practitioners, and

(C) alleged criminal perpetrators.

(c) **Uses**

(1) Routine uses

(A) Users. The bureau of laboratory services data system is used by:

(i) physicians;

(ii) lawyers;

(iii) officials of state agencies;

(iv) judiciary department staff;

(v) laboratory supervisors; and

(vi) federal agencies.

(B) Purpose. The bureau of laboratory services data system is used for:

(i) diagnosis of disease;

(ii) appraisal of environmental conditions; and

(iii) testimony to support laboratory findings in court.

(2) Retention. Records for each personal data system are maintained in accordance with schedules prepared by the Connecticut State Library, Department of Public Records Administration and records retention schedule as approved by the Public Records Administrator as authorized by section 11-8a of the Connecticut General Statutes. Retention schedules shall be maintained on file at the office of the official responsible for the data

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system and may be examined during normal business hours.

(Adopted effective August 24, 1995)

Sec. 19a-2a-14. Local health administration system

(a) **General nature and purpose**

(1) Location. This system is located at 150 Washington Street, Hartford, Connecticut.

(2) Format. The system is a combined automated and manual system.

(3) Purpose. The purpose of this system is to provide the department with:

(A) data to assure compliance with subsection (a) of Section 19a-200 and Section 19a-242 of the Connecticut General Statutes regarding qualifications of local directors of health and their appointments;

(B) data to assure compliance with sections 19a-202 and 19a-245 of the Connecticut General Statutes and sections 19a-76-1 to 19a-76-4 of the regulations of Connecticut State Agencies regarding use of state funding for local health departments and health districts; and

(C) data on the organization and management of local health departments and districts in the state pursuant to subsection (a) of Section 19a-200 of the Connecticut General Statutes.

(4) Official responsible. The director of the office of local health administration is located at 150 Washington Street, Hartford, Connecticut, and is the official responsible for the system. Requests for disclosure or amendment of the records in the system should be directed to this official.

(5) Routine sources. Personal data in this system is routinely obtained from:

(A) local directors of health and their staff;

(B) potential candidates for director of health or other local health staff positions;

(C) educational institutions;

(D) civil service commissions; and

(E) boards of health.

(6) Legal authority. The legal authority for this system is Connecticut General Statutes, Sections:

(A) 19a-200;

(B) 19a-202;

(C) 19a-206;

(D) 19a-241;

(E) 19a-242;

(F) 19a-243;

(G) 19a-244; and

(H) 19a-245.

(b) **Categories**

(1) The categories of personal data maintained in the local health administration system include, but are not necessarily limited to:

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(A) educational and professional background materials, including but not limited to resumes or curricula vitae, educational transcripts, letters of reference, appointments, and removal from office;

(B) names, addresses, telephone numbers, birth dates, educational backgrounds, salaries and conditions of employment for local directors of health and their staff;

(C) fees, expenses, and charges for services to the towns by part-time directors of health and submitted to the commissioner for approval; and

(D) letters of complaint filed against local directors of health, their departments, or staff, results of investigations, and recommendations for disciplinary actions.

(2) There are no categories of other data maintained by the local health administration system.

(3) Categories of persons on whom records are maintained are:

(A) local health directors; and

(B) persons appointed by local health directors.

(c) **Uses**

(1) Routine uses

(A) Users. The system is used by program staff.

(B) Purpose. The system is used to assure compliance with the general statutes regarding qualifications of local directors of health and their appointments and the use of state funding for local health departments and districts, and to provide aggregated data on the organization and management of local health departments and districts in the state.

(2) Retention. Records for each personal data system are maintained in accordance with schedules prepared by the Connecticut State Library, Department of Public Records Administration and records retention schedule as approved by the Public Records Administrator as authorized by section 11-8a of the Connecticut General Statutes. Retention schedules shall be maintained on file at the office of the official responsible for the data system and may be examined during normal business hours.

(Adopted effective August 24, 1995)

Sec. 19a-2a-15. Newborn screening system

(a) **General nature and purpose**

(1) Location. The newborn screening system is located at 999 Asylum Avenue, Hartford, Connecticut.

(2) Format. Personal data is stored in the newborn screening system in a manual form.

(3) Purpose

The purpose of the newborn screening system is to track infants found to have a serious problem as a result of a blood test done right after birth.

(4) Official responsible. The director, maternal infant health division is located at 999 Asylum Avenue, Hartford, Connecticut, and is the official responsible for the newborn screening system. Requests for disclosure or amendment of the records in the system should be directed to this official.

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(5) Routine sources. Personal data in the newborn screening system is received from any laboratory carrying out a newborn screening test.

(6) Legal authority. The collection, maintenance and use of personal data in the newborn screening system is authorized by Connecticut General Statutes, Section 19a-55.

(b) Categories

(1) The categories of personal data maintained by the newborn screening section include, but are not necessarily limited to:

- (A) name of infant;
- (B) name and age of mother;
- (C) sex of infant;
- (D) birthdate of infant;
- (E) address of mother and father;
- (F) telephone number of parents;
- (G) place of birth of infant; and
- (H) medical information on the infant.

(2) The category of other data maintained in the newborn screening system is information on services received by infant.

(3) Categories of persons on whom records are maintained are:

- (A) newborn infants; and
- (B) parents of newborn infants.

(c) Uses

(1) Routine uses

(A) Users. The newborn screening system is used by program staff.

(B) Purpose. The newborn screening system is used to ensure that the infant received proper treatment and follow-up.

(2) Retention. Records for each personal data system are maintained in accordance with schedules prepared by the Connecticut State Library, Department of Public Records Administration and records retention schedule as approved by the Public Records Administrator as authorized by section 11-8a of the Connecticut General Statutes. Retention schedules shall be maintained on file at the office of the official responsible for the data system and may be examined during normal business hours.

(Adopted effective August 24, 1995)

Sec. 19a-2a-16. Personnel data system

(a) General nature and purpose

(1) Location. Personnel records for employees of the department are maintained at 150 Washington Street, Hartford, Connecticut.

(2) Format. Personal data is stored in the personnel data system in both automated and manual form.

(3) Purpose. The purpose of the personnel data system is to carry out the personnel and payroll responsibilities of the department in a manner consistent with the state's prescribed

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policies and procedures.

(4) Official responsible. Personnel records are the responsibility of the Personnel Administrator, 150 Washington Street, Hartford, Connecticut. Requests for disclosure or amendment of the records in the system should be directed to this official.

(5) Routine sources. Personal data in the personnel data system is routinely obtained from:

- (A) employees;
- (B) supervisors;
- (C) the Comptroller's Office;
- (D) insurance companies;
- (E) credit unions;
- (F) banks;
- (G) the department;
- (H) previous employers of employees;
- (I) the Department of Administrative Services, Division of Personnel; and
- (J) references supplied by applicants.

(6) Legal authority. The legal authority for the collection, maintenance and use of the personal data in the system is Connecticut General Statutes, Sections 5-193 through 5-269.

(b) Categories

(1) The categories of personal data maintained by the personnel data system include, but are not necessarily limited to:

- (A) name;
- (B) address;
- (C) date of birth;
- (D) social security number;
- (E) employment history;
- (F) education;
- (G) payroll data; and
- (H) labor relations and union related data.

(2) The category of other data maintained by the personnel data system includes but is not necessarily limited to a history of who has worked within each position.

(3) Categories of people upon whom personnel records are maintained are:

- (A) employees;
- (B) applicants for employment; and
- (C) past employees.

(c) Uses

(1) Routine uses

(A) Users. The personnel data system is used by the department's personnel and payroll offices and the department's administration.

(B) Purpose. The personnel data system is used for:

- (i) ensuring that applicants for employment meet prescribed qualifications; and

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(ii) ensuring that candidates for promotion meet prescribed qualifications.

(2) Retention. Records for each personal data system are maintained in accordance with schedules prepared by the Connecticut State Library, Department of Public Records Administration and records retention schedule as approved by the Public Records Administrator as authorized by section 11-8a of the Connecticut General Statutes. Retention schedules shall be maintained on file at the office of the official responsible for the data system and may be examined during normal business hours.

(Adopted effective August 24, 1995)

Sec. 19a-2a-17. Contract administration data system

(a) General nature and purpose

(1) Location. The contract administration data system is maintained at 150 Washington Street, Hartford, Connecticut.

(2) Format. Personal data is stored in the contract administration data system in both automated and manual forms.

(3) Purpose. The purpose of the contract administration data system is to:

(A) ensure that contracts are awarded in a manner consistent with state policies and procedures; and

(B) to ensure contracts are administered in a manner consistent with state policies and procedures.

(4) Official responsible. The director of contract administration at 150 Washington Street, Hartford, Connecticut is responsible for the contract administration data system. Requests for disclosure or amendment of the records in the system should be directed to this official.

(5) Routine sources. Personal data in the contract administration data system is routinely obtained from:

(A) consultants;

(B) contractors; and

(C) subcontractors.

(6) Legal authority. Collection, maintenance and use of personal data in the contract administration data system is authorized by Connecticut General Statutes Sections:

(A) 4-8; and

(B) 19a-32.

(b) Categories

(1) The categories of personal data maintained by the contract administration data system include, but are not necessarily limited to:

(A) names of:

(i) consultants;

(ii) contractors;

(iii) subcontractors;

(B) address of:

(i) consultants;

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- (ii) contractors;
 - (iii) subcontractors;
 - (C) resumes of consultants;
 - (D) time sheets and salary records of consultants;
 - (E) social security numbers of:
 - (i) consultants;
 - (ii) contractors;
 - (iii) subcontractors; and
 - (F) federal employee identification numbers of:
 - (i) consultants;
 - (ii) contractors; and
 - (iv) subcontractors.
 - (2) There are no categories of other data maintained by the contract administration data system.
 - (3) The categories of persons on whom records are maintained are:
 - (A) consultants;
 - (B) contractors;
 - (C) subcontractors; and
 - (D) service providers.
 - (c) **Use**
 - (1) Routine uses
 - (A) Users. The contract administration data system is used by department staff.
 - (B) Purpose. The contract administration data system is used for:
 - (i) internal audits of contractor services;
 - (ii) financial audits; and
 - (iii) financial management.
 - (2) Retention. Records for each personal data system are maintained in accordance with schedules prepared by the Connecticut State Library, Department of Public Records Administration and records retention schedule as approved by the Public Records Administrator as authorized by section 11-8a of the Connecticut General Statutes. Retention schedules shall be maintained on file at the office of the official responsible for the data system and may be examined during normal business hours.
- (Adopted effective August 24, 1995)

Sec. 19a-2a-18. Supplemental food program for women, infants and children (WIC) system

- (a) **General nature and purpose**
 - (1) Location. The WIC system is located at 999 Asylum Avenue, Hartford, Connecticut.
 - (2) Format. Personal data is stored in the WIC system in both automated and manual forms.
 - (3) Purpose. The purpose of the WIC system is to provide the WIC program with data

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regarding participants.

(A) Participant information is maintained for documentation of certification of eligibility as well as to enable the issuance of WIC checks to eligible participants.

(B) Nutrition surveillance information is maintained to track the health status of certain individuals, and maintain documentation on food stores and pharmacies who apply to become authorized program vendors as well as currently authorized vendors.

(4) Official responsible. The state WIC director is located at 999 Asylum Avenue, Hartford, Connecticut, and is the official responsible for the WIC system. Requests for disclosure or amendment of the records in the system should be directed to this official.

(5) Routine sources. Personal data in the WIC system is routinely obtained from:

(A) the program participants; and

(B) vendors who apply to become authorized WIC program vendors.

(6) Legal authority. Collection, maintenance and use of the WIC data system is authorized by Section 19a-59c of the Connecticut General Statutes.

(b) Categories

(1) The categories of personal data maintained by the WIC system include, but are not necessarily limited to:

(A) names;

(B) sex;

(C) address;

(D) race;

(E) telephone numbers;

(F) medical information;

(G) date of birth; and

(H) family income.

(2) The category of other data maintained by the WIC system is names of parents and guardians.

(3) The categories of persons on whom records are maintained are:

(A) program participants; and

(B) vendors who apply to be authorized program vendors.

(c) Uses

(1) Routine uses

(A) Users. The WIC system is used by program staff.

(B) Purpose. The WIC system is used for:

(i) program accountability;

(ii) program evaluation; and

(iii) eligibility determination of applicants and vendors.

(2) Retention. Records for each personal data system are maintained in accordance with schedules prepared by the Connecticut State Library, Department of Public Records Administration and records retention schedule as approved by the Public Records Administrator as authorized by section 11-8a of the Connecticut General Statutes. Retention

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schedules shall be maintained on file at the office of the official responsible for the data system and may be examined during normal business hours.

(Adopted effective August 24, 1995)

Sec. 19a-2a-19. Division of medical quality assurance, professional licensure applications system

(a) **General nature and purpose**

(1) Location. The division of medical quality assurance is located at 150 Washington Street, Hartford, Connecticut.

(2) Format. Personal data is stored in both manual and automated forms.

(3) Purpose. The purpose of the division of medical quality assurance, professional licensure system is to ensure that persons working in regulated professions meet standards of eligibility and conform to professional standards.

(4) Official responsible. The director for the division of medical quality assurance is located at 150 Washington Street, Hartford Connecticut, and is the official responsible for this system. Requests for disclosure or amendment of the records in the system should be directed to this official.

(5) Routine sources. Personal data in the division's system is routinely obtained from:

- (A) applicants;
- (B) references for applicants;
- (C) educational institutions;
- (D) training programs;
- (E) employers; and
- (F) consumer complainants.

(6) Legal authority. The division of medical quality assurance professional licensure system is authorized by Connecticut General Statutes, Sections 19a-511 through 19a-520, and chapters:

- (A) 369 through 376a;
- (B) 377 through 381a;
- (C) 383 through 388;
- (D) 398; and
- (E) 399.

(b) **Categories**

(1) The categories of personal data maintained include, but are not necessarily limited to:

- (A) name;
- (B) address;
- (C) social security number;
- (D) licensure status in other states;
- (E) educational and training;
- (F) professional references;

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- (G) work history; and
- (E) data pertaining to complaints; investigations, and disciplinary actions.
- (2) There are no categories of other data maintained by this system.
- (3) The categories of persons on whom records are maintained are applicants for and holders of licensure, certification, or registration within a regulated profession.

(c) **Uses**

(1) Routine uses

(A) Users. The system is used by department staff, third party payers, data banks, health care consumers, and health care employers.

(B) Purpose. The system is used to identify persons allowed to work within regulated professions.

(2) Retention. Records for each personal data system are maintained in accordance with schedules prepared by the Connecticut State Library, Department of Public Records Administration and records retention schedule as approved by the Public Records Administrator as authorized by section 11-8a of the Connecticut General Statutes. Retention schedules shall be maintained on file at the office of the official responsible for the data system and may be examined during normal business hours.

(Adopted effective August 24, 1995)

Sec. 19a-2a-20. Payroll records data system

(a) **General nature and purpose**

(1) Location. Payroll records for all department employees, are maintained at 150 Washington Street, Hartford, Connecticut.

(2) Format. Payroll records are maintained in automated and manual forms.

(3) Purpose. The purpose of the system is to facilitate the department's activities regarding payroll, budgeting, cost accounting, personnel planning and compliance with state and federal reporting requirements.

(4) Official responsible. The Chief Administrator of Fiscal Services is located at 150 Washington Street, Hartford, Connecticut, and is the official responsible for the payroll records data system. Requests for disclosure or amendment of the records in the system should be directed to this official.

(5) Routine sources. Routine sources of information in payroll records include:

- (A) employee;
- (B) employee's supervisor;
- (C) attendance sheets;
- (D) contracts;
- (E) the Comptroller's Office;
- (F) the Department of Administrative Services;
- (G) the Division of Personnel and Labor Relations; and
- (H) insurance carriers.

(6) Legal authority. Payroll data are collected, maintained and used under authority of

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the State Personnel Act, Connecticut General Statutes Section 5-193 through 5-269.

(b) Categories

(1) Categories of personal data maintained in payroll files include, but are not necessarily limited to:

- (A) name;
- (B) address;
- (C) social security number;
- (D) date of birth;
- (E) telephone number;
- (F) marital status;
- (G) insurance;
- (H) retirement information;
- (I) military service;
- (J) correspondence regarding payroll and benefits matters;
- (K) financial information such as salary records;
- (L) longevity payments;
- (M) compensation plan;
- (N) rate of pay;
- (O) deductions;
- (P) salary history;
- (Q) garnishment of wages;
- (R) payments related to garnishment;
- (S) employment information such as starting date;
- (T) job classification and bargaining unit;
- (U) attendance information;
- (V) vacation;
- (W) sick and personal leave days accrued and used;
- (X) title of position; and
- (Y) contracts.

(2) No categories of other data are maintained.

(3) The categories of persons on whom records are maintained include all current and former department employees.

(c) Uses

(1) Routine uses

(A) Users. Payroll records are used by the fiscal department staff.

(B) Purpose. The payroll records data system is used:

- (i) to plan payroll and calculate budgets;
- (ii) to process promotions, reclassifications, transfers to other state agencies and retirements; and
- (iii) to maintain personnel documents required by the Comptroller's Office, the Department of Administrative Services, Division of Personnel, and group insurance carriers.

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(2) Retention. Records for each personal data system are maintained in accordance with schedules prepared by the Connecticut State Library, Department of Public Records Administration and records retention schedule as approved by the Public Records Administrator as authorized by section 11-8a of the Connecticut General Statutes. Retention schedules shall be maintained on file at the office of the official responsible for the data system and may be examined during normal business hours.

(Adopted effective August 24, 1995)

Sec. 19a-2a-21. Employee assistance program (EAP) data system

(a) General Nature and Purpose

(1) Location. All EAP client records are located in the Employee Assistance Program, 150 Washington Street, Hartford, Connecticut.

(2) Format. Records are maintained in automated and manual form.

(3) Purpose

The purpose of this system is to document the diagnosis, treatment planning, treatment process and response of the EAP client.

(4) Official responsible. The affirmative action officer is located at 150 Washington Street, Hartford, Connecticut, and is the official responsible for the EAP data system. Requests for disclosure or amendment of the records in the system should be directed to this official.

(5) Routine sources. Routine sources of data include interviews, examinations, observations or evaluations of the patient or client, information provided by family members, public and private health care providers, social workers, and professionals and other state agencies.

(6) Legal authority. Personnel data in EAP client records are collected, maintained and used under authority of Section 19a-126h of the Connecticut General Statutes and 42 C.F.R. (Code of Federal Regulations) Part 2.

(b) Categories

(1) Categories of personal data maintained in EAP client records include, but are not necessarily limited to:

(A) job performance information such as a description of performance deficiencies and presenting problems;

(B) salary, length of employment, place of employment and job description;

(C) source of referral, such as self, employer or supervisor, labor union or other;

(D) medical and emotional condition or history;

(E) family or personal relationships;

(F) treatment referrals;

(G) name;

(H) address;

(I) telephone number;

(J) date of birth;

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- (K) sex;
- (L) racial or ethnic designation;
- (M) social security number; and
- (N) health insurance information.
- (2) No categories of other data are collected.

(3) The category of individuals upon whom personal data are collected includes those individuals seeking assistance from the Employee Assistance Program.

(c) **Uses**

(1) Routine uses

(A) Users. Records are used by the EAP staff to reflect treatment planning and services provided to or on behalf of EAP clients and their families.

(B) Purpose. The purpose of this system is to document the diagnosis, treatment planning, treatment process and response of the EAP client.

(2) Retention. Records for each personal data system are maintained in accordance with schedules prepared by the Connecticut State Library, Department of Public Records Administration and records retention schedule as approved by the Public Records Administrator as authorized by section 11-8a of the Connecticut General Statutes. Retention schedules shall be maintained on file at the office of the official responsible for the data system and may be examined during normal business hours.

(Adopted effective August 24, 1995)

Sec. 19a-2a-22. AIDS/HIV data system

(a) **General nature and purpose**

(1) Location. All data collected in the AIDS/HIV data system is housed at 21 Grand Street, Hartford, Connecticut.

(2) Format. This data system is all automated.

(3) Purpose. The purpose for this system is disease surveillance.

(4) Official responsible. The chief of the Epidemiology Section/AIDS division is located at 21 Grand Street, Hartford, Connecticut, and is the official responsible for the AIDS/HIV data system. Requests for disclosure or amendment of the records in this system should be directed to this official.

(5) Routine sources. Personal data is routinely received from physicians, institutions, laboratories, infection control practitioners, AIDS coordinators in various health care facilities or private practice, and from death certificates.

(6) Legal authority. The legal authority for the AIDS/HIV data system is Connecticut General Statutes, Sections:

- (A) 19a-2a; and
- (B) 19a-581 through 19a-592.

(b) **Categories**

(1) Categories of personal data collected on individuals in the AIDS/HIV data system include the following:

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- (A) name;
- (B) address;
- (C) date of birth;
- (D) sex;
- (E) various diseases experienced by these individuals;
- (F) risk categories;
- (G) laboratory tests; and
- (H) date of death, if applicable.

(2) No other data is collected.

(3) Categories of persons on whom data is collected include:

- (A) adults with CDC-defined AIDS; and
- (B) all children who are HIV exposed or infected.

(c) **Uses**

(1) Routine uses

(A) Users. The routine users of the data are the staff epidemiologists employed by the AIDS division.

(B) Purpose

- (i) To monitor the occurrence and progression of HIV/AIDS disease in Connecticut;
- (ii) to target populations for intervention;
- (iii) to evaluate the effect of HIV/AIDS prevention initiatives; and
- (iv) to project the number of cases that will occur in the future and plan for health care resources.

(2) Retention. Records for each personal data system are maintained in accordance with schedules prepared by the Connecticut State Library, Department of Public Records Administration and records retention schedule as approved by the Public Records Administrator as authorized by section 11-8a of the Connecticut General Statutes. Retention schedules shall be maintained on file at the office of the official responsible for the data system and may be examined during normal business hours.

(Adopted effective August 24, 1995)

Sec. 19a-2a-23. Maintenance of personal data

(a) Personal data shall not be maintained unless relevant and necessary to accomplish the lawful purposes of the department. Where the department finds irrelevant or unnecessary public records in its possession, it shall dispose of these records in accordance with its records retention schedule and with the approval of the public records administrator as per Connecticut General Statutes section 11-8a, or if the records are not disposable under the records retention schedule, request permission from the public records administrator to dispose of the records under Connecticut General Statutes section 11-8a.

(b) The department shall collect and maintain all records accurately and completely.

(c) Insofar as it is consistent with the needs and mission of the department, the department wherever practical shall collect personal data directly from the persons to whom

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a record pertains.

(d) Department employees involved in the operations of the department's personal data systems shall be informed of the provisions of:

(1) the Personal Data Act, chapter 55 of the Connecticut General Statutes;
(2) the department's regulations adopted pursuant to Connecticut General Statutes section 4-196;

(3) the Freedom of Information Act, Sections 1-15 and 1-18 to 1-211 inclusive of the Connecticut General Statutes; and

(4) any other state or federal statutes or regulations concerning maintenance or disclosure of personal data kept by the department.

(e) All department employees shall take reasonable precautions to protect personal data under their custody from the danger of fire, theft, flood, natural disaster and other physical threats.

(f) The department shall incorporate by reference the provisions of the Personal Data Act and regulations promulgated thereunder in all contracts, agreements, or licenses for the operation of a personal data system or for research, evaluation and reporting of personal data for the department or on its behalf.

(g) The department shall ensure that personal data requested and received from any other agency is maintained in conformance with Connecticut General Statutes, Section 4-190 et seq., and sections 19a-2a-1 through 19a-2a-23 of the regulations of Connecticut State Agencies.

(h) Only department employees who have a specific need to review personal data records for lawful purposes of the department shall be entitled to access to such records under the Personal Data Act.

(i) The department shall maintain a written up-to-date list of individuals entitled to access to each of the agency's personal data systems.

(j) The department shall ensure against unnecessary duplication of personal data records. In the event it is necessary to send personal data records through interdepartmental mail, such records shall be sent in envelopes or boxes sealed and marked "confidential."

(k) The department shall ensure that all records in manual personal data systems are kept under lock and key and, to the greatest extent practical, are kept in controlled access areas.

(l) With respect to automated personal data systems, the department shall:

(1) to the greatest extent practical, locate automated equipment and records in a limited access area;

(2) to the greatest extent practical, require visitors to such areas to sign a visitor's log and permit access to said area on a bona-fide need-to-enter basis only;

(3) to the greatest extent practical, ensure that regular access to automated equipment is limited to operations personnel; and

(4) utilize appropriate access control mechanisms to prevent disclosure of personal data to unauthorized individuals.

(m) When an individual is asked by the department to supply personal data about himself

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or herself, the department, upon request, shall disclose to that individual:

- (1) the name of the division within the department requesting the personal data;
 - (2) the legal authority under which the department is empowered to collect and maintain the personal data;
 - (3) the individual's right pertaining to such records under the Personal Data Act and sections 19a-2a-1 through 19a-2a-23 of the regulations of Connecticut State Agencies;
 - (4) the known consequences arising from supplying or refusing to supply the requested personal data;
 - (5) the proposed use to be made of the requested personal data;
 - (6) except where non-disclosure is required or specifically permitted by law, the department shall disclose to any person upon written request all personal data concerning that individual which is maintained by the department. The department's procedures for disclosure shall be in accordance with Connecticut General Statutes, sections 1-15 through 1-21k. If the personal data is maintained in coded form, the department shall transcribe the data into a commonly understandable form before disclosure;
 - (7) the department is responsible for verifying the identity of any person requesting access to his or her own personal data;
 - (8) the department is responsible for ensuring that disclosure made pursuant to the Personal Data Act is conducted so as not to disclose any personal data concerning persons other than the person requesting the information;
 - (9) the department may refuse to disclose to a person, medical, psychiatric or psychological data on that person if the department determines that such disclosure would be detrimental to that person;
 - (10) in any case where the department refuses disclosure it shall advise that person of his or her right to seek judicial relief pursuant to the Personal Data Act;
 - (11) if the department refuses to disclose medical, psychiatric or psychological data to a person based on its determination that disclosure would be detrimental to that person and non-disclosure is not mandated by law, the department shall, at the written request of such person, permit a qualified medical doctor to review the personal data contained in the person's record to determine if the personal data should be disclosed. If disclosure is recommended by the person's medical doctor, the department shall disclose the personal data to such person; if non-disclosure is recommended by such person's medical doctor, the department shall not disclose the personal data and shall inform such person of the judicial relief provided under the Personal Data Act; and
 - (12) the department shall maintain a complete log of each person, individual, agency or organization who has obtained access or to whom disclosure has been made of personal data under the Personal Data Act, together with the reason for each disclosure or access. This log shall be maintained for not less than five (5) years from the date of such disclosure or access or for the life of the personal data records, whichever is longer.
- (n) **Contesting the content of personal data records:**
- (1) Any person who believes that the department is maintaining inaccurate, incomplete

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or irrelevant personal data concerning him or her may file a written request with the department for correction of said personal data.

(2) Within thirty (30) days of receipt of such request, the official of the department who is responsible for maintaining the records, shall give written notice to that person that the department will make the requested correction, or if the correction is not to be made as submitted, the official of the department shall state the reason for the department's denial of such request and notify the person of his or her right to add his or her own statement to his or her personal data records.

(3) Following such denial by the department, the person requesting such correction shall be permitted to add a statement to his or her personal data record setting forth what that person believes to be an accurate, complete and relevant version of the personal data in question. Such statements shall become a permanent part of the department's personal data system and shall be disclosed to any individual, agency or organization to which the disputed personal data is disclosed.

(Adopted effective August 24, 1995)

J1 Visa Waiver Program

Sec. 19a-2a-24. Definitions

As used in sections 19a-2a-24 to 19a-2a-26, inclusive, of the Regulations of Connecticut State Agencies:

(1) "Department" means the Department of Public Health.

(2) "Application" means an application for waiver of a two-year foreign residence requirement for a foreign medical graduate holding a J-1 VISA.

(3) "Applicant" means a physician or surgeon licensed pursuant to Chapter 370 of the Connecticut General Statutes, on whose behalf an application is being filed.

(4) "Fiscal Year" means the period October 1st through September 30th.

(5) "Health Care Facility" means a medical facility, as defined in 42 C.F.R. Section 5.2, as amended from time to time.

(6) "Director" means the Director of the United States Information Agency (USIA).

(Adopted effective June 2, 1997; Amended December 22, 2009)

Sec. 19a-2a-25. Applications

(a) An application form for a J-1 VISA waiver shall be developed by the Department and shall be disseminated by the Department upon request to health care facilities or applicants. Such application form shall request all information and documentation deemed necessary by the Department, in accordance with federal laws, to ensure that the Department will be able to submit the completed application materials to the Director on behalf of an applicant.

(b) A health care facility shall submit a completed application to the Department on

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behalf of an applicant.

(Adopted effective June 2, 1997)

Sec. 19a-2a-26. Eligibility determination

(a) If an application contains all of the necessary information and documentation, as set forth in the application and as required by federal regulation, 22 C.F.R. section 41.63, the application may be approved by the Department. If information is missing from the application, the Department shall not approve the application.

(b) The Department shall forward to the Director the first thirty approved applications in the fiscal year. The Department shall recommend that the United States Attorney General grant J-1 VISA waivers to such thirty applicants.

(c) Notwithstanding the above procedures, if the Department determines that there is a shortage of physicians or surgeons in a specific specialty or in a specific geographic location within the area designated by the Secretary of Health and Human Services, the Department may forward to the Director an approved application for such specialty or geographic location, even though such application may not be one of the first thirty applications approved by the Department during the fiscal year. The Department shall document the basis for its decision to forward and recommend an application that is not among the first thirty applications approved during the fiscal year.

(d) Each application submitted in accordance with subsection (a) of this section prior to April 1 of each fiscal year, shall be taken in order of submission if deemed complete, thereafter if the total number of applications has not reached thirty, applications shall be considered in order of submission and may include applications from a physician or surgeon who (1) agrees to practice medicine in a health care facility that is located in a geographic area designated by the United States Secretary of Health and Human Services as having a shortage of health care professionals, or (2) agrees to practice medicine in a health care facility that serves patients who reside in one or more geographic areas designated by the United States Secretary of Health and Human Services as having a shortage of health care professionals without regard to whether such facility is located within such a designated area, provided that in addition to the requirements of Section 19a-2a-25(a), all of the following conditions are met:

(A) the health care facility shall document that a minimum of thirty percent (30%) of the applicant physician's patients reside in an area designated by the United States Secretary of Health and Human Services as having a shortage of health care professionals;

(B) the health care facility shall provide a description of why the physician's services are required and how the applicant physician's work will benefit the indigent and medically underserved; and

(C) the health care facility shall provide letters of community support from at least three (3) community agencies stating that the J-1 placement is critical and will help alleviate health care access problems for the underserved population of the community.

(e) In no event shall the number of applications approved pursuant to subsection (d)(2)

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of this section exceed the federally designated maximum for Conrad Flex spots per fiscal year. In no event shall more than two waivers approved pursuant to subsection (d)(2) be recommended per health care facility in each fiscal year, unless by April 30 of that fiscal year the number of applications approved pursuant to subsection (d)(2) and recommended from all institutions do not reach the maximum for Conrad Flex spots for that fiscal year.

(Adopted effective June 2, 1997; Amended February 4, 2004; Amended December 22, 2009)

Sec. 19a-2a-27—19a-2a-28. Reserved

Sec. 19a-2a-29. Family campgrounds

(a) **Purpose.** The intent of this section is to provide minimum design and construction requirements to ensure a reasonable degree of public health and safety for occupants using facilities supplied by family campgrounds which offer temporary living sites for use by recreational vehicles, camping trailers, and other camping units.

(b) **Definitions.**

(1) “Atmospheric vacuum breaker” means a mechanical device that automatically air vents a pipeline to prevent backsiphonage;

(2) “Camping trailer” means a vehicular camping unit mounted on wheels and constructed with collapsible sidewalls that fold for towing by another vehicle and unfold at the camping unit site to provide temporary living quarters for recreation, camping or travel;

(3) “Camping unit” means a portable structure, shelter, or vehicle having a gross trailer area not exceeding 400 square feet designed and intended for occupancy by persons engaged in recreational camping. Camping units include but are not limited to recreational vehicles, recreational park trailers, camping cabins, housekeeping cabins, tents, tepees, yurts and other rental accommodations that have no hard electrical wiring and no permanent drainage plumbing;

(4) “Camping unit site” means a specific area within a family campground set aside for use by a camping unit;

(5) “Department” means the Connecticut Department of Public Health;

(6) “Family campground “ means any location, property, parcel or tract of land under the control of any person, organization, or municipality that contains two or more camping unit sites for use by the public or members of an organization for overnight stays;

(7) “Fifth wheel trailer” means a vehicular camping unit, mounted on wheels, designed to provide temporary living quarters for recreation, camping or travel, of such size or weight as not to require special highway movement permit(s), and designed to be towed by a motorized vehicle that contains a towing mechanism above or forward of the tow vehicle’s rear axle;

(8) “Gross trailer area” means the total plan area measured to the maximum horizontal projection of exterior walls in the setup mode;

(9) “Motor home” means a vehicular camping unit designed to provide temporary living quarters for recreational, camping, or travel use built on or permanently attached to a self-propelled motor vehicle chassis or on a chassis cab or van that is an integral part of the

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completed vehicle;

(10) “Primitive campground” means a family campground where no facilities or designated camping unit sites are provided for the comfort or convenience of the campers;

(11) “Public water system” means any water provider supplying water to fifteen (15) or more consumers or twenty-five (25) or more persons, based upon the “Design Population” as defined in section 16-262m-8(a)(3) of the Regulations of Connecticut State Agencies jointly administered by the department and the Department of Public Utility Control, daily at least sixty (60) days of the year;

(12) “Recreational park trailer” means a trailer-type camping unit that is primarily designed to provide temporary living quarters for recreational camping that meets the following criteria:

(A) Be built on a single chassis mounted on wheels;

(B) have a gross trailer area not exceeding 400 square feet, and

(C) be certified by the manufacturer as complying with ANSI A119.5.

(13) “Recreational vehicle” means a vehicular-type camping unit primarily designed as a temporary living quarters for recreation, camping or travel that either has its own motive power or is mounted on or towed by another vehicle. The basic entities included are camping trailer, fifth wheel trailer, motor home, travel trailer and truck camper;

(14) “Sanitary disposal station” means a facility provided for emptying of camping unit wastewater storage tanks;

(15) “Semi-primitive campground” means a family campground where designated camping unit sites are not provided and where some rudimentary facilities (privies and/or fireplaces) may be provided for the comfort and convenience of the campers;

(16) “Suitable acre” means dry land available for camping unit site development;

(17) “Travel trailer” means a vehicular camping unit, mounted on wheels, designed to provide temporary living quarters for recreation, camping, or travel and of such size or weight as not to require special highway movement permits when towed by a motorized vehicle;

(18) “Truck camper” means a portable camping unit constructed to provide temporary living quarters for recreation, camping, or travel, consisting of a roof, floor, and sides designed to be loaded onto and unloaded from the bed of a pickup truck;

(19) “Water riser pipe” means that portion of the water system serving a camping unit or camping unit site that extends from the water supply main through a lateral branch and terminates at a water connection; and,

(20) “Water supply station” means a facility for supplying drinking water to campers or camping unit water storage tanks.

(c) General Provisions.

(1) Registration with the local director of health. Each person, firm or corporation operating a family campground shall register annually in writing with the local director of health of the town, borough, city or health district in which such family campground is located. No person, firm, or corporation shall operate or maintain any family campground

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without first obtaining local permits or licenses if such permits or licenses are required by local ordinance or regulation. The written registration shall include the name and location of the family campground, the name, address and telephone number of the person responsible for daily operations at the facility, the number of camping unit sites, and the expected dates of operation, if not open year round. All family campgrounds shall submit annual registrations between January 1st and April 30th of each year of operation.

(2) Responsibility of the local director of health. The local director of health or his or her authorized agent shall inspect annually each family campground. If it is found to be operating in such a manner that constitutes a public health hazard or public health nuisance, the local director of health shall investigate and cause the abatement of such condition. Any person, firm or corporation aggrieved by an order issued by the local director of health, may within three business days after receipt of such order, appeal to the Commissioner of Public Health in accordance with section 19a-229 of the Connecticut General Statutes.

(3) Records. The owner, firm or corporation shall maintain a daily register of all camping unit site occupants or camping unit occupants and groups at the family campground. Such register shall include the name of the family head or the responsible group member, his or her permanent address, dates of arrival and departure, and motor vehicle license plate number if applicable. The registration form shall indicate the site or unit assigned and the classification of the vehicle.

(4) Fire Safety Rules and Regulations. Family campground management shall conspicuously post fire safety rules and regulations. These postings shall contain the following minimum information and any other additional information required by the local fire marshal:

- (A) The telephone number of the fire department or location of nearest fire alarm box;
- (B) the telephone number of the police department;
- (C) the telephone number, name and address of the family campground; and,
- (D) the location of the nearest public telephone.

(5) First Aid Information. Family campground management shall maintain on-site a fully equipped first aid kit equivalent to an American National Red Cross Standard 24 Unit Kit and conspicuously post the location of said first aid kit. Each family campground shall have a public telephone available at all times for use by the occupants and have available a directory of local hospitals, ambulance services, police and fire departments.

(6) Accident Report Requirements. Report forms, describing an accident or injury, shall be completed in duplicate by family campground management for each injury or fatality that occurs at a family campground requiring attendance by an emergency medical service, a nurse, physician, or the police. Information on the report forms shall include the name, age and sex of the victim, relevant background data on the accident, injury classification, response data, diagnosis, and patient disposition. The accident report form shall be maintained at the family campground for a minimum of 1 year.

(7) Camping Unit Site Space Allotment. The number of camping unit sites shall be limited to not more than fifteen per suitable acre, except for camping unit sites serving

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overnight or transient campers, where the density shall be limited to twenty-five camping unit sites per suitable acre.

(8) Public swimming pools and public swimming areas. Public swimming pools and public swimming areas, if provided within a family campground, shall comply with sections 19-13-B33b and 19a-36-B61 of the Regulations of Connecticut State Agencies for all public swimming pools and public swimming areas

(d) Water Supply and Distribution.

(1) General Requirements. The water supply provided at each family campground shall be from a source approved by the department and capable of supplying an adequate quantity to meet all the requirements of the maximum number of persons using the family campground at any one time. The quantity shall be sufficient to serve all peak occupancy demands maintaining 25 psi throughout the distribution system. Each public water system serving a family campground shall comply with the water quality requirements of section 19-13-B102 of the Regulations of Connecticut State Agencies. Wells used for public water supply shall comply with the requirements of section 19-13-B51a to 19-13-B51m, inclusive of the Regulations of Connecticut State Agencies.

(2) Water Distribution System. The water supply shall be easily obtainable from water riser pipes, water outlets, or water supply stations located within 500 feet walking distance from any camping unit or camping unit site, except for primitive or semi-primitive campgrounds. Water distribution piping shall be of approved materials, adequately protected from leakage, damage and vandalism. The size and design shall be such as to provide adequate pressure throughout the system at all times. The water distribution system shall be protected against the hazard of backflow as required in section 19-13-B38a of the Regulations of Connecticut State Agencies. If a water riser pipe is not available at every camping unit site, a central water supply station with suitable appurtenances for filling water storage tanks shall be provided. All central water supply stations shall be located a minimum of 25 feet from any sanitary disposal station. All central water supply stations shall be equipped with atmospheric vacuum breakers located downstream of the last shutoff valve. Adjacent to the central water supply station, a sign of not less than 24 inch by 24 inch in size shall be posted and inscribed thereon in clearly legible letters on a contrasting background shall be: "DRINKING WATER - NOT TO BE USED FOR FLUSHING WASTEWATER STORAGE TANKS". Water lines that are seasonally drained shall be disinfected when returned to service. A laboratory approved by the department prior to the beginning of each season shall perform water sampling and the water sample(s) shall be absent for total coliform bacteria prior to public use of the water supply. Disinfection shall be provided to all sections of water lines after completion of emergency repairs to assure safe potable water supply service. Water sampling shall be performed after the completion of emergency repair work to confirm the absence of total coliform bacteria. The sampling location(s) shall include at least one location downstream of the repair work.

(3) Water Riser Pipes. When provided, water riser pipe connections for individual camping unit sites shall be equipped with a threaded male spigot with the opening pointed

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down, located at least 12 inches but not more than 24 inches above grade level for the attachment of a standard water hose. Each water riser pipe connection shall be equipped with an atmospheric vacuum breaker located downstream from the last shutoff valve.

(e) Sanitary Facilities.

(1) General Requirements. Sanitary facilities consisting of flush toilets, lavatories and showers with hot and cold running water shall be provided at one or more locations in every family campground except at primitive or semi-primitive campgrounds. The sanitary facilities shall be located within 500 feet walking distance from all camping units or camping unit sites not provided with an individual sewer connection or scheduled camping unit wastewater storage tank pump out service. Camping unit sites provided with individual sewer connections or scheduled camping unit wastewater storage tank pump out service may be at greater distances from sanitary facilities. All toilet buildings shall provide separate facilities for males and females and shall be appropriately marked. All toilet buildings shall be properly screened with self-closing doors and be vented to the roof. Structures built to house toilets, lavatories and showers shall be constructed of smooth non-absorbent easily cleanable materials and shall be kept clean and sanitary at all times. Separate compartments shall be provided for each toilet and shower. Unisex shower compartments may be utilized only if they are not located within public toilet areas. Each female toilet room shall be provided with a receptacle for sanitary napkins. The receptacle shall be of durable, non-absorbent, and readily cleanable material and shall be provided with a lid. Privies, chemical toilets or other non-flush toilets, and portable lavatories may be used in family campgrounds when approved by the local director of health. The local director of health shall approve methods of disposal of domestic sewage including gray water at primitive and semi-primitive campgrounds.

(2) Number of Sanitary Fixtures. Sanitary fixtures shall be provided for all family campgrounds except at primitive or semi-primitive campgrounds in accordance with the following minimum criteria.

Camping Unit Sites	Flush Toilets		Urinals	Lavatories		Showers	
	Men	Women	Men	Men	Women	Men	Women
0 - 25	1	1	1	1	1	1	1
26 - 50	2	3	1	2	2	2	2
51 - 75	3	4	2	3	3	3	3
76 - 100	4	5	2	4	4	4	4

For family campgrounds with more than 100 camping unit sites, additional toilets, urinals, lavatories and showers shall be provided for men and women at the ratio of 1 each for every additional 30 camping unit sites or part thereof. For those family campgrounds that provide camping unit sites with individual sewer connections or scheduled camping unit wastewater storage tank pump out service, the minimum number of sanitary fixtures required beyond 50 camping unit sites shall be reduced by 1 for every 10 camping unit sites with those

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services to no lower than the minimum number of fixtures required for 50 camping unit sites.

(f) Subsurface Sewage Disposal.

(1) Subsurface Sewage Disposal at Family Campgrounds with Design Flows of 5,000 Gallons per Day or Less. All subsurface sewage disposal systems shall be installed in compliance with section 19-13-B103a to 19-13-B103f inclusive of the Regulations of Connecticut State Agencies. Plans for every new subsurface sewage disposal system, repair, alteration or extension of an existing subsurface sewage disposal system, including gray water disposal systems, shall be reviewed and approved by the local director of health. No subsurface sewage disposal system shall be installed unless the local director of health has issued an approval to construct nor shall the system be used unless a permit to discharge has been issued by the local director of health in accordance with section 19-13-B103e of the Regulations of Connecticut State Agencies. Each subsurface sewage disposal system shall be constructed by a person licensed pursuant to Chapter 393a of the Connecticut General Statutes.

(2) Subsurface Sewage Disposal at Family Campgrounds with Design Flows Greater than 5,000 Gallons per Day. On those properties where the sewage design flow exceeds 5,000 gallons per day, plan review, permits to construct, permits to discharge and approvals shall be obtained from the Department of Environmental Protection as required by section 22a-430 of the Connecticut General Statutes.

(g) Sanitary Disposal Station.

(1) General Requirements. In all family campgrounds except primitive and semi-primitive campgrounds, one sanitary disposal station shall be provided for each 150 camping unit sites that are not provided with individual sewer connections or scheduled pump out service for the camping unit wastewater storage tank. Each station shall be level, easily accessible from the service road, and shall provide easy entry and exit for recreational vehicles and recreational park trailers.

(2) Sanitary Disposal Station Requirements. Sanitary disposal stations shall be located a minimum of 50 feet from camping unit sites. Each sanitary disposal station shall have a concrete slab with a 4-inch center drain inlet located so as to be on the roadside (left) of the recreational vehicle or recreational park trailer. The drain shall be equipped with self-closing foot-operated hatch of approved material with a tight fitting cover. The drain shall be properly connected to a septic tank or non-discharging holding tank. The slab shall be not less than 3 feet by 3 feet and at least 3½ inches thick and properly reinforced, trowelled smooth and sloped from each side toward the center drain. A water tap with suitable hose and appurtenances shall be provided at the sanitary disposal station for periodic cleanup of the area. A reduced pressure principal backflow preventer (RPD) shall be installed on the water supply line to this tap. Each RPD shall be tested annually by a distribution system backflow preventer operator certified pursuant to section 25-32-11(e) of the Regulations of Connecticut State Agencies. The owner shall promptly restore any malfunctioning RPD to proper operating condition. Adjacent to the water tap located at the sanitary disposal station,

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a sign of durable material not less than 24 inches by 24 inches in size shall be posted and inscribed thereon in clearly legible letters on a contrasting background shall be: “DANGER-NOT TO BE USED FOR DRINKING OR DOMESTIC PURPOSES”.

(3) Sanitary Disposal Station Holding Tanks. Watertight non-discharging holding tanks may be installed for the temporary storage of camping unit wastewater dumped at the sanitary disposal station. Such holding tanks shall be equipped with high level alarms or indicators and have an access manhole extended to grade. The local director of health and the department shall approve installation of sanitary disposal station holding tanks. Wastewater from sanitary disposal station holding tanks shall be pumped and disposed of by individuals licensed pursuant to Chapter 393a of the Connecticut General Statutes.

(4) Mobile Pump Out Services. Family campgrounds may provide mobile pump out services for camping unit wastewater storage tanks for camping unit sites not served by individual sewer connections. The wastewater collected by the mobile pump out unit must be disposed of at the sanitary disposal station. Mobile pump out units and equipment shall be maintained in a clean and sanitary condition. Water used for rinsing mobile pump out equipment shall be considered wastewater and shall be disposed of in a sanitary manner. Accidental spillage of camping unit storage tank wastewater shall be promptly removed or otherwise abated so as to prevent a nuisance or public health hazard.

(h) Food Service Establishments.

(1) Serving Food, Dispensing Machines. Food and beverages sold at family campgrounds shall be stored and dispensed in accordance with sections 19-13-B40 and 19-13-B42 of the Regulations of Connecticut State Agencies. Food or beverage vending machine operation shall conform to the requirements of section 19-13-B52 of the Regulations of Connecticut State Agencies.

(i) General Sanitation.

(1) Refuse. The storage, collection and disposal of refuse at family campgrounds shall be such as to create no health hazards, rodent harborage, insect breeding, odors, wild animal attractions, unsightliness or other nuisance conditions. An adequate number of fly tight metal or heavy plastic containers shall be provided and conspicuously located to facilitate refuse storage and disposal.

Such containers shall be kept covered at all times. Final disposal of refuse shall be in an approved manner and location in compliance with local and state regulations.

(2) Insects, Rodents, Wild Animals. Grounds, buildings and structures at family campgrounds shall be maintained free of and in such a manner to prevent infestation by rodents, breeding of flies, mosquitoes or other insects, or depredation by animals. The local director of health shall require control measures if any nuisance condition is observed.

(3) Camping Unit Site Drainage, General Site Protection. Each camping unit site shall be selected, arranged and improved in such a manner as to promote proper drainage and eliminate flooding and mosquito breeding areas. Poison ivy and other noxious plants shall be removed from the camping unit site. No safety hazard or nuisance condition shall be

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allowed to remain on all camping unit sites.

(Adopted effective December 27, 2005; Amended March 17, 2014)

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Subject

Confidentiality of Health Care Data

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Confidentiality of Health Care Data

Sec. 19a-7-1. Definitions

As used in sections 19a-7-1 and 19a-7-2 of the Regulations of Connecticut State Agencies:

(1) “Agent” means a person or entity which has entered into an agreement or contract with the department to perform administrative, processing, management, analytical, evaluative, or other related service with the data collected under Section 19a-7(b) of the Connecticut General Statutes;

(2) “Aggregate health data” means health data that are obtained by adding together like data in a manner that precludes the identification of an individual described by the data;

(3) “Commissioner” means the commissioner of the Department of Public Health;

(4) “Confidential health data” means personal data or patient-identifiable data collected under Section 19a-7(b) of the Connecticut General Statutes;

(5) “Department” means the Department of Public Health;

(6) “Disseminate” or “disclose” means the communication of health data to any individual or organization outside the department;

(7) “Health data” means information collected under Section 19a-7(b) of the Connecticut General Statutes, recorded in any form or medium, that relates to the health status of individuals, the determinants of health and health hazards, the availability of health resources and services, or the use and cost of such resources and services;

(8) “Individual” means a natural person;

(9) “Organization” means any corporation, association, partnership, agency, department, unit, or other legally constituted institution or entity, or part thereof;

(10) “Patient” means an individual who has received health care services and from whom health data have been obtained;

(11) “Patient-identifiable data” means any information that singly or collectively refers to one patient and permits positive or probable identification of that patient;

(12) “Personal data” means “personal data” as defined in Section 4-190 of the Connecticut General Statutes;

(13) “Process of establishing a state health plan” means the activities by which the department collects, analyzes, evaluates, and disseminates health data in order to develop public health priorities, goals, and objectives, or other related functions as determined by the commissioner;

(14) “Public health planning” means any activity conducted by the department as provided in Section 19a-7 of the Connecticut General Statutes; and

(15) “Report” means data or information extracted or prepared in any form or medium.

(Adopted effective February 25, 2000)

Sec. 19a-7-2. Maintenance of confidentiality

(a) Access to confidential health data shall be restricted to those employees or agents engaged in the department’s process of establishing a state health plan.

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(b) The department may, at the discretion of the commissioner, disseminate aggregate health data or publish reports based upon aggregate health data provided such data and reports:

- (1) are used for public health planning and
- (2) do not include personal data or patient-identifiable data.

(c) The department may not disclose confidential health data unless:

- (1) the disclosure is to the data's provider for purposes of quality assurance; or
- (2) the disclosure is to an individual, organization, governmental entity in this or another state or to the federal government, provided the department determines that:

(A) based upon a written application and such other information as required by the department to be submitted by the requesting individual, organization or governmental entity, the data will be used solely for public health planning;

(B) the disclosure of data to the requesting individual, organization or governmental entity is required for the public health planning proposed;

(C) the requesting individual, organization or governmental entity has entered into a written agreement satisfactory to the department agreeing to protect such data in accordance with the requirements of this section and not permit disclosure without prior approval of the department; and

(D) the requesting individual, organization or governmental entity, upon request of the department or after a specified date or event, returns or destroys all confidential health data provided by the department and copies thereof in any form.

(Adopted effective February 25, 2000)

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Reporting Information to and Releasing Information from the Connecticut Immunization Registry and Tracking System

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Reporting Information to and Releasing Information from the Connecticut Immunization Registry and Tracking System

Sec. 19a-7h-1. Definitions

As used in Sections 19a-7h-1 to 19a-7h-5, inclusive, of the Regulations of Connecticut State Agencies:

(1) “Connecticut electronic birth registry system” means the department’s computer database of all birth data from electronic transmission of birth information data by hospitals to the department as authorized by section 7-48 of the Connecticut General Statutes.

(2) “Department” means the Connecticut Department of Public Health.

(3) “Health care provider” means “health care provider” as defined in section 19a-7h of the Connecticut General Statutes.

(4) “Immunization registry” means the department’s ongoing computer-based registry of children who have not yet begun first grade of school and their complete immunization history as authorized by section 19a-7h of the Connecticut General Statutes.

(Adopted effective May 1, 2000)

Sec. 19a-7h-2. Registration

(a) The administrator of the Connecticut electronic birth registry system shall report identifying and locating information and, to the extent the information is contained in it, any information on in-hospital newborn vaccination, non-household contact persons, and designated well child care provider, to the immunization registry on all children born on or after January 1, 1999 in Connecticut hospitals to residents of Connecticut.

The administrator of the Connecticut electronic birth registry system shall submit an electronic data file to the immunization registry administrator within 7 days of the information being received at the department. Identifying and locating information shall be:

(1) the infant’s name, birthdate, hospital of birth, birth certificate number, birth document control number, and address, and, if available, social security number;

(2) the infant’s mother’s name, birthdate, and address; and

(3) the infant’s father’s name, birthdate and address.

(b) Health care providers who vaccinate or, when appropriate, provide an exemption from vaccination to any child who resides in Connecticut, was born out-of-state on or after January 1, 1999, and is not yet enrolled in the first grade, shall report registration information on that child to the immunization registry, on a form provided by the immunization registry, within fourteen days of providing the initial in-state vaccination or permanent vaccination exemption to that child. Registration information shall be,:

(1) the child’s name, birthdate, state of birth, current address, telephone number, and, if available, social security number;

(2) the child’s parent(s)’s or legal guardian(s)’s name(s), date(s) of birth, current address, telephone number; and

(3) the name, work address and work telephone number of the child’s primary well child

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care provider.

(c) Any health care provider who vaccinates any child who resides in Connecticut and was born on or after October 1, 1994, may report any known change of identifying or locating information on that child each time a change becomes known to that health care provider.

(Adopted effective May 1, 2000)

Sec. 19a-7h-3. Reporting of vaccination by health care providers

(a) Health care providers giving vaccinations in an outpatient setting shall report to the immunization registry information on each vaccination given to a child born on or after January 1, 1999 and who currently resides in Connecticut, or when appropriate, permanent exemptions from administration of each vaccine dose within 14 days of giving to or permanently exempting a child from any dose of vaccine. Health care providers shall make similar reports at the request of the immunization registry administrator on children enrolled in the immunization registry including those born before January 1, 1999. Reports shall be made in a written or an electronic format, approved by the commissioner. The reports shall include:

(1) the vaccinated or exempted child's name and date of birth and, if the report is made in electronic format, other unique identifiers approved by the commissioner;

(2) the name of each vaccination given or for permanent exemption, the name of each vaccine exempted and whether the exemption is for medical reasons, religious reasons, or because the child has laboratory confirmation of natural infection with the infecting agent against which the exempted vaccine would provide protection;

(3) the date the vaccine was administered or permanently exempted; and

(4) the name of the health care provider who ordered the dose be given or in the case of a permanent exemption, issued a medical exemption or provided evidence of laboratory confirmation of natural infection.

(b) In the case of a hospital neonatal care unit, the chief executive officer of the hospital shall designate a hospital employee to be responsible for reporting any vaccination given to a newborn child before the newborn child is discharged from the hospital inpatient setting. Reports shall be made within fourteen days of administering a vaccination. Where reports can be made through the Connecticut electronic birth registry system together with the birth registration information, vaccination may be reported through that system. Where that is not possible, reports shall be made in a written or an electronic format approved by the commissioner. A biweekly listing of births and vaccination status of each newborn child may be substituted for individual vaccination reports. The reports shall include:

(1) the vaccinated child's name, date of birth and hospital of birth;

(2) the biologic mother's name;

(3) the name of each vaccination given;

(4) the date the vaccine was administered.

(c) When requested by the immunization registry to provide immunization information

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on a named child, the current or former health care provider of any such child enrolled in the immunization registry shall provide to the immunization registry that child's immunization history and identifying information as required in subsection (a) of this section within fourteen days of such request.

(Adopted effective May 1, 2000)

Sec. 19a-7h-4. Release of information by the immunization registry

(a) Health care providers intending to administer vaccines to a child who need to know a child's immunization history for purposes of determining whether additional doses of vaccine are needed and health care providers who need to officially document a child's immunization status to meet state day care or school immunization entry requirements and who have signed a written statement on a form provided by the department stating that they have read section 19a-7h of the Connecticut General Statutes and sections 19a-7h-1 through 19a-7h-5 inclusive of the Regulations of Connecticut State Agencies and will comply with them shall be allowed to obtain information from the immunization registry about the immunization status of children in it. Health care providers shall provide the immunization registry with sufficient identifying information to identify an individual child and shall be provided a complete record of that child's immunization status, including name and date of each vaccine dose given or permanently exempted, and name and birthdate of the child. The immunization registry shall provide the immunization record either via a secure computer connection at the time of the query, via fax to a telephone number given by the health care provider, via telephone followed by mailing or faxing of a written or printed copy, by written or printed copy, or by other such methods determined by the commissioner to assure that the report is being made to a health care provider who has agreed in writing to comply with Connecticut General Statutes section 19a-7h and sections 19a-7h-1 through 19a-7h-5 inclusive of the Regulations of Connecticut State Agencies. Such written statements shall be renewed every twenty-four months and shall be kept on file for seven years in the immunization program of the department.

(b) Parents or guardians of a child may request and obtain a written or printed copy of their child's immunization record directly from the immunization registry central office.

(1) The copy provided shall include the child's name, date of birth, and the name and date of each vaccine dose given or exempted. If a vaccine is permanently exempted, the copy shall state whether the exemption is because the child already has evidence of immunity or because the child has a contraindication to vaccination, which may be either medical or religious as specified in section 19a-7h-3 of the Regulations of Connecticut State Agencies, and is still thought to be susceptible to the infectious agent against which the exempted vaccination is meant to protect. It shall not have additional identifying information, including current or past addresses of the child. The copy shall contain a statement that the record was provided by the Connecticut State Immunization Registry and can be used as an official immunization record for licensed day care and school entry purposes.

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(2) If a parent or guardian of the child directly requests a copy of the immunization record from the immunization registry, such request shall be made in person or by mail, and photographic identification shall be presented, if available. Should a photographic identification be unavailable, originals or photocopies of any two of the following documents may be substituted for it:

- (A) social security card;
- (B) written verification of identity from employer;
- (C) current automobile registration;
- (D) current copy of utility bill showing name and address;
- (E) current checking account deposit slip stating name and address;
- (F) current voter registration card.

(c) Local directors of health who have signed a written statement on a form provided by the department that they have read section 19a-7h of the Connecticut General Statutes and sections 19a-7h-1 through 19a-7h-5 inclusive of the Regulations of Connecticut State Agencies and will comply with them, shall have full access to all necessary registration and immunization information in the immunization registry for all children who are registered as residing in their health jurisdiction to enable them to determine which children are overdue for scheduled immunizations and to enable them to provide outreach by mail, telephone or on-site visits after first conferring with the child's last known primary care provider.

(1) The immunization registry shall provide the immunization records either by computer connection or written or printed copy.

(2) At the health director's discretion, outreach workers working on behalf of the local health department to improve immunization levels may be given sufficient information to identify and locate individual children who are behind on immunization and to inform their parents or guardians which generic vaccines are still needed.

(Adopted effective May 1, 2000)

Sec. 19a-7h-5. Refusing participation in the immunization registry

The parent or guardian of any child who is listed or eligible to be listed in the immunization registry shall receive a written informational statement from the department about the immunization registry at the time of birth or, for qualifying children who come to Connecticut after birth, at the time of their coming to the attention of the immunization registry. Such statement shall inform the parent or guardian that their child's immunization information will be reported to and maintained by the immunization registry and that they may submit a written request to the immunization registry at any time requesting that their child's immunization record no longer be maintained. Once the request is received, the immunization registry shall no longer update nor make available that child's immunization record as specified in section 19a-7h-4 of the Regulations of Connecticut State Agencies.

(Adopted effective May 1, 2000)

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Sec. 19a-9-1. Definitions

As used in sections 19a-9-2 through 19a-9-29 of the Regulations of Connecticut State Agencies:

(1) “Adjudicating agency” means the agency with the responsibility of issuing the final decision or declaratory ruling in a given case.

(2) “Agency” means the Department of Public Health, or any board or officer within said department authorized by law to make regulations or to determine contested cases.

(3) “Applicant” means a person who has applied for licensure by the department.

(4) “Board” means any professional board of examiners or commission created by statute within the department.

(5) “Commissioner” means the Commissioner of Public Health or the Commissioner’s designee.

(6) “Complaint” means a formal statement of charges issued by the department.

(7) “Contested case” has the meaning provided in section 4-166 of the Connecticut General Statutes.

(8) “Day” means a calendar day.

(9) “Department” means the Department of Public Health.

(10) “Hearing officer” has the meaning provided in section 4-166 of the Connecticut General Statutes.

(11) “Hearing panel” means a panel consisting of board members, designated by the board to conduct a hearing.

(12) “Institution” means what is specified in subsection (a) of section 19a-490 of the Connecticut General Statutes.

(13) “Intervenor” means a person, other than a party, who is allowed to participate in either a contested case or a hearing on a request for declaratory ruling, as set forth in section 4-177a of the Connecticut General Statutes, and section 19a-9-27 of the Regulations of Connecticut State Agencies.

(14) “License” has the meaning provided in section 4-166 of the Connecticut General Statutes.

(15) “Licensee” means a person who holds a license issued by the department.

(16) “Notice of hearing” means the notice required to be provided to the parties pursuant to subsections (a) and (b) of section 4-177 and section 4-182(c), if applicable, of the Connecticut General Statutes.

(17) “Party” has the meaning provided in section 4-166 of the Connecticut General Statutes.

(18) “Person” has the meaning provided in section 4-166 of the Connecticut General Statutes.

(19) “Petition” means a claim of violation of a statute or regulation committed by a health professional or institution or other entity under the jurisdiction of the agency or department, including an appeal filed with the commissioner pursuant to section 19a-535 or 19a-535a

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of the Connecticut General Statutes.

(20) “Petitioner” means a person bringing a petition before the commissioner or department.

(21) “Presiding officer” has the meaning provided in section 4-166 of the Connecticut General Statutes.

(22) “Respondent” means any person who is the subject of a petition or against whom a statement of charges has been issued by the department.

(23) “Request for a declaratory ruling” means a request made by any person for a ruling on the validity of any regulation or the applicability to specified circumstances of a provision of the general statutes, a regulation, or a final decision on a matter within the jurisdiction of the agency.

(24) “Request for regulation making” means a request made by any person for the promulgation, amendment, or repeal of a regulation of the department.

(25) “Statement of charges” means a formal complaint issued by the agency either after an investigation of a petition or at the department’s own initiative.

(Adopted effective September 4, 1997)

Sec. 19a-9-2. Organization description

(a) The department operates under the direction of its commissioner who is appointed by the Governor.

(b) The commissioner has the powers and duties specified in section 19a-2a and other provisions of the Connecticut General Statutes.

(c) The principal office of the department and each board is located at and all communications should be addressed to the Department of Public Health, P. O. Box 340308, 410 Capitol Avenue, Hartford, Connecticut 06134-0308. This office is open from 8:30 a.m. to 4:30 p.m. Monday through Friday except legal holidays.

(d) The public may inspect the regulations, decisions and all public records of each agency at the department’s office. Requests for public information shall be in writing and submitted to the department at the address in subsection (c) of this section.

(Adopted effective September 4, 1997)

Rules of Practice

Receipt and Investigation of Petitions and Adjudication of Complaints

ARTICLE ONE

General Provisions

Sec. 19a-9-3. Application and severability of regulations

(a) Sections 19a-9-1 through 19a-9-29 of the Regulations of Connecticut State Agencies govern practices and procedures before the Department of Public Health and the various

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professional examining boards and commissions within the department, under the applicable laws of the State of Connecticut except where statutes and regulations otherwise provide.

(b) Each regulation in the provisions of sections 19a-9-1 through 19a-9-29 of the Regulations of Connecticut State Agencies and every part of each such regulation is severable. The holding of any regulation or part thereof to be unconstitutional, void or ineffective for any reason shall not affect the validity, enforceability or constitutionality of any other regulation or part thereof.

(Adopted effective September 4, 1997)

Sec. 19a-9-4. Waiver of rules

Where good cause appears, except where precluded by statute, the presiding officer or agency may permit deviation from sections 19a-9-1 through 19a-9-29 of the Regulations of Connecticut State Agencies.

(Adopted effective September 4, 1997)

Sec. 19a-9-5. Construction

Sections 19a-9-1 through 19a-9-29 of the Regulations of Connecticut State Agencies shall be construed liberally by the agency or presiding officer to secure a just and efficient determination of the issues presented.

(Adopted effective September 4, 1997)

Sec. 19a-9-6. Filing papers

(a) **General.** All motions shall be submitted in writing stating the order or relief requested and the grounds therefor. A document or other writing is deemed submitted when personally delivered, mailed through the United States Postal Service or delivered in a manner specified by the agency and is deemed received when stamped by the agency as received.

(b) In all matters other than contested cases and declaratory ruling actions, all correspondence, motions, petitions, applications, and any other document governed by sections 19a-9-1 through 19a-9-29 of the Regulations of Connecticut State Agencies, except for those documents specified in subsection (d) of this section, shall be filed by delivering the original and two (2) copies by personal delivery or by United States mail addressed to the agency unless otherwise specified, and shall be deemed to have been filed on the date on which they are stamped received by the agency at its principal office. If any such document is to be considered at an agency meeting, it shall be filed no later than fourteen (14) days before the scheduled meeting. Any responsive document shall be filed no later than seven (7) days before any such meeting.

(c) In contested cases and declaratory ruling actions, all correspondence, motions, answers, responses and any other document, except for those documents specified in subsection (d) of this section, shall be filed by delivering the original and two (2) copies by personal delivery or United States mail addressed to the department or in the manner specified in the agency's notice of hearing. Such documents shall be deemed to have been

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filed on the date on which they are stamped received by the agency at its principal office. Any party or intervenor shall also serve copies of such documents on all other parties and intervenors by personal delivery or United States mail. The filing and such other service of documents shall be accompanied by a certification of service to all other parties and intervenors, identified by their names and addresses.

(1) Documents filed in conjunction with a matter to be considered at an agency meeting shall be filed no later than fourteen (14) days before the scheduled agency meeting unless otherwise ordered by the agency or presiding officer. Responsive documents shall be filed no later than seven (7) days before the agency meeting unless otherwise ordered by the agency or presiding officer.

(2) Documents filed before a hearing commences shall be filed within fourteen (14) days after the date of the notice of the hearing. Any response shall be filed within fourteen (14) days after such document is filed.

(3) Documents filed after a hearing commences or an agency meeting has been held in which the matter is considered, shall be filed and responded to within the time determined by the presiding officer or agency. If a response time has not been determined by the presiding officer or agency, a response shall be filed not later than five business days after such document is filed.

(d) Subsections (b) and (c) of this section shall not apply to motions for summary suspension, proposed consent orders, proposed interim consent orders, pre-hearing review documents, and motions to withdraw charges.

(Adopted effective September 4, 1997; Amended December 8, 2004)

Sec. 19a-9-7. Extension of time for filing

Upon application, for good cause shown, the presiding officer or adjudicating agency may extend the time within which any document may be filed.

(Adopted effective September 4, 1997)

Sec. 19a-9-8. Date due when due date falls on a date the department is closed

If the last day of any statutory or regulatory time frame falls on a day on which the department is closed, any paper may be filed or any required action may be taken on the next business day the department is open. Such filing or action shall be deemed to have the same legal effect as if done prior to the expiration of the time frame.

(Adopted effective September 4, 1997)

ARTICLE TWO

**Procedure for Filing Petitions, Requests for Declaratory Rulings and Rulemaking,
and Appeals of Orders Issued by Local Directors of Health**

Sec. 19a-9-9. Who may file a petition

Any person may file a petition whenever that person has cause to believe that any health

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professional or institution licensed by the department, or other entity under the jurisdiction of the department, has been engaged or is engaging in any practice that violates a statute or regulation.

(Adopted effective September 4, 1997)

Sec. 19a-9-10. Petition contents

(a) A petition shall be in writing and shall contain the following:

- (1) the full name and address of the petitioner;
- (2) the full name and address of the respondent;
- (3) a plain and simple statement of the facts, events or actions on which the claim is based;

- (4) the date and approximate time of the alleged violation; and,

- (5) the location where the alleged violation occurred.

(b) A petition shall not be deemed defective solely because of the absence of one or more of the items contained in subsection (a) of this section.

(Adopted effective September 4, 1997)

Sec. 19a-9-11. Modification or withdrawal of a petition

A petition, or any part thereof, may be withdrawn or modified by the petitioner with the consent of the department upon such conditions as the department may deem proper.

(Adopted effective September 4, 1997)

Sec. 19a-9-12. Requests for declaratory rulings

Any interested person may submit a request to the agency for a declaratory ruling regarding the validity of any regulation, or applicability to specified circumstances of a provision of the general statutes, a regulation, or a final decision on a matter within the jurisdiction of the agency. The submittal shall conform to the requirements of subsection 19a-9-6(a), and a copy shall be sent to any person that the requester knows or has reason to believe may be substantially affected by the declaratory ruling. It shall contain a detailed statement of the person's interest in such matter and the facts relevant thereto, and the names and addresses of persons to whom it was sent. The agency may request the submission of such additional facts as it deems necessary, and may conduct a hearing.

(Adopted effective September 4, 1997)

Sec. 19a-9-13. Request for regulation

Requests for the promulgation, amendment or repeal of a regulation shall be in writing and contain the reasons for the requested action. The department shall act in the manner specified in section 4-174 of the Connecticut General Statutes.

(Adopted effective September 4, 1997)

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Sec. 19a-9-14. Appeals of orders issued by a town, city, borough, or district director of health

(a) Any person aggrieved by an order issued by a town, city, borough, or district director of health may appeal said order to the commissioner.

(b) The notice of appeal shall be filed with the commissioner not later than three business days after the date of such person's receipt of such order.

(c) The notice of appeal shall state:

(1) the name, address, and telephone number of the person claiming to be aggrieved;

(2) the name of the issuing authority;

(3) the way in which the order adversely affects the person claiming to be aggrieved;

(4) the order being appealed; and

(5) the grounds for appeal.

(d) Telephonic notice of appeal to the office of the commissioner shall be satisfactory as the initial notice of appeal, provided written notice of appeal from the person claiming to be aggrieved is received by the department within ten (10) days of the telephonic notice.

(e) An appeal from an order issued by a town, city, borough, or district director of health shall be a *de novo* proceeding conducted in accordance with the regulations governing contested cases as set forth in sections 19a-9-1 through 19a-9-29 of the Regulations of Connecticut State Agencies.

(f) Any order issued by a town, city, borough, or district director of health shall include notice of the right to appeal which shall indicate the name and telephone number of the commissioner or the commissioner's designee, and shall be accompanied by copies of sections 19a-9-8 and 19a-9-14 of the Regulations of Connecticut State Agencies.

(Adopted effective September 4, 1997; Amended December 8, 2004)

ARTICLE THREE

Investigations

Sec. 19a-9-15. Agency's authority to investigate, refer and dismiss petitions and requests for declaratory rulings

(a) The agency may initiate and conduct any investigation that the agency deems necessary within the agency's jurisdiction.

(b) If, after receipt or investigation of a petition or request for a declaratory ruling, the agency determines that it lacks jurisdiction or that there is insufficient evidence to establish the alleged violation, it shall dismiss the petition or request. The agency shall notify the petitioner or the person making the request, and any respondent who is the subject of the investigation, in writing, of the dismissal. The agency may, in the exercise of discretion, refer any petition or request to another person, agency, or department within the executive or judicial branch.

(Adopted effective September 4, 1997)

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Sec. 19a-6-16. Applications for reconsideration of dismissals of petitions and requests for declaratory rulings

A petitioner or a person who requests a declaratory ruling may request reconsideration of a dismissal by the agency within ten (10) days from the date of the notice of the dismissal. The request shall be in writing and shall specify the grounds upon which it is based. New or previously unknown evidence may then be considered.

(Adopted effective September 4, 1997)

ARTICLE FOUR

Post-Investigative Procedures

Sec. 19a-9-17. Designation of hearing entity

If the agency determines that the evidence is sufficient to issue a statement of charges or to hold a hearing on a request for a declaratory ruling, or if the legal rights, duties or privileges of a party are required by statute to be determined by the commissioner or an agency after an opportunity for hearing, the adjudicating agency may designate a hearing officer, a member of the agency or a hearing panel to conduct a hearing, unless otherwise provided by statute.

(Adopted effective September 4, 1997)

Sec. 19a-9-18. Notice of hearing

(a) All notices of hearing shall be in writing and shall comply with the provisions of subsections (a) and (b) of section 4-177 and subsection (c) of section 4-182, if applicable, of the Connecticut General Statutes, as they may be amended from time to time.

(b) A notice of hearing shall be delivered to all designated parties and intervenors or their authorized representative personally or by United States mail, certified or registered, postage prepaid, return receipt requested.

(c) A notice of hearing shall be effective if delivered or sent to the party's last known address of record on file with the department. If such notice is not actually received by a party, or if the party is not currently licensed, service shall be deemed sufficient provided that the department or board, if applicable, has made all reasonable efforts to effectuate notice.

(Adopted effective September 4, 1997)

Sec. 19a-9-19. Filing of answer in a contested case

(a) An answer shall be in writing, signed by a respondent or his or her authorized representative, and shall be filed with the agency within fourteen (14) days from the date of the notice of the hearing, or such other time specified in the notice of hearing.

(b) An answer shall contain a specific denial, admission, or denial of any knowledge sufficient to form a belief regarding each allegation of the complaint, and a statement of any facts or claims that may constitute a defense.

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(c) Any allegation not answered in accordance with subsection (b) of this section shall be deemed admitted.

(d) An answer shall contain the mailing address and telephone number of the respondent, and the mailing address and telephone number of the respondent's authorized representative, if any.

(Adopted effective September 4, 1997)

Sec. 19a-9-20. Failure to file answer in a contested case

The presiding officer shall proceed with the hearing at the time and place specified in the notice of hearing, notwithstanding any failure of the respondent to file an answer within the time provided. If no answer has been timely filed, the allegations shall be deemed admitted.

(Adopted effective September 4, 1997)

Sec. 19a-9-21. Acceleration of hearings

With the approval of the presiding officer, the parties to any proceeding may consent by written stipulation to a hearing earlier than that provided in the notice of the hearing.

(Adopted effective September 4, 1997)

Sec. 19a-9-22. Joinder of proceedings

Two (2) or more hearings on requests for declaratory rulings, or two (2) or more contested cases against a respondent may be joined together by the presiding officer in the presiding officer's discretion, provided that in hearings conducted pursuant to sections 19a-535 and 19a-535a of the Connecticut General Statutes, as they may be amended from time to time, two (2) or more proceedings may be joined only when the sole issue involved is one of federal or state law or policy.

(Adopted effective September 4, 1997)

Sec. 19a-9-23. Continuation of hearing

The presiding officer may continue a hearing from day to day or adjourn it to a later date or to a different place by announcement thereof at the hearing or by other appropriate notice, at the presiding officer's discretion.

(Adopted effective September 4, 1997)

ARTICLE FIVE

Hearing Procedures for Contested Cases and Declaratory Ruling Proceedings

Sec. 19a-9-24. Hearings

Hearings shall be conducted in accordance with Chapter 54 of the Connecticut General Statutes. The rules of evidence shall be as prescribed in section 4-178 of the Connecticut

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General Statutes.

(Adopted effective September 4, 1997)

Sec. 19a-9-25. Powers and duties of the presiding officer

The presiding officer shall rule on all motions and preside at the hearing. If a hearing is held before less than a majority of the members of a board who are authorized by law to render a final decision, a majority of the members of a board shall review all rulings on dispositive motions and shall render the final decision. If a hearing is held before a hearing officer or hearing panel authorized to issue a final decision, the hearing officer or hearing panel shall also rule on all dispositive motions. If the hearing officer or hearing panel is authorized to issue a proposed final decision, the hearing officer or hearing panel shall issue proposed rulings on dispositive motions. Proposed rulings on dispositive motions shall be reviewed at the same time and in the same manner as proposed final decisions.

(Adopted effective September 4, 1997)

Sec. 19a-9-26. Designation of parties

(a) Designation as a party in contested cases. In addition to any parties designated in the agency's notice of hearing, the presiding officer may designate other parties in accordance with applicable law.

(b) Designation as a party in actions for declaratory rulings. Any person who proposes to be admitted as a party to an action for a declaratory ruling shall file a written request to be so designated with the adjudicating agency, and shall mail copies of the request to all parties and intervenors not later than seven (7) days before the date of the hearing of the proceeding. The request shall state:

- (1) the name and address and telephone number of the person filing the request and that of the person's authorized legal representative, if any;
- (2) the manner in which the person making the request claims to be substantially and specifically affected by the proceeding;
- (3) the factual and legal issues to be addressed in the proceeding;
- (4) the relief sought;
- (5) the statutory or other authority for such relief; and
- (6) a summary of any evidence that the person making the request intends to present.

(Adopted effective September 4, 1997)

Sec. 19a-9-27. Designation as an intervenor

(a) **Request to participate.** A request to participate as an intervenor in a contested case or declaratory ruling hearing shall be in writing and mailed to the agency and all parties and intervenors at least five (5) days before the date of the hearing.

(b) **Contents of request.** The request of the proposed intervenor shall:

- (1) state such person's name and address;
- (2) state the interest affected by the proceeding;

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(3) describe the manner and extent to which such person proposes to participate in the hearing;

(4) describe the manner in which such participation will furnish assistance to the agency in resolving the issues; and

(5) summarize any evidence such person proposes to offer.

(c) **Designation as intervenor.** The presiding officer shall determine whether and to what extent the proposed intervenor may participate in the hearing, taking into account whether such participation will furnish assistance to the agency in resolving the issues.

(Adopted effective September 4, 1997)

Sec. 19a-9-28. Notice of appearance in contested cases and actions for declaratory ruling and proceedings

Each party and intervenor or their duly authorized representative shall file a written notice of appearance with the presiding officer prior to the commencement of the hearing.

(Adopted effective September 4, 1997)

Sec. 19a-9-29. Miscellaneous provisions

(a) Order of presentation in actions for declaratory rulings. The order of presentation shall be determined by the presiding officer at the time of the hearing.

(b) Order of presentation in contested cases. The order of presentation shall be determined by the presiding officer at the time of the hearing, and shall provide the parties with the rights and privileges set forth in sections 4-177 et seq., of the Connecticut General Statutes, as they may be amended from time to time.

(c) Limiting testimony. The presiding officer may limit the number of witnesses or the time for testimony upon a particular issue in the course of any hearing in order to avoid unnecessary cumulative evidence.

(d) Limitation of direct case in actions for declaratory rulings. The direct case of any party shall consist substantially of the written statement in the request for declaratory ruling, and the exhibits and other materials annexed thereto unless the presiding officer shall rule otherwise for good cause shown.

(e) Upon request of any party or intervenor or on his own motion, the presiding officer may require any party or other participant who proposes to offer technical or expert written testimony to provide such testimony to any or all other parties or intervenors, and to prefile such testimony with the presiding officer, prior to or during the course of the hearing. Such prefiled written testimony may subsequently be received in evidence, with the same force and effect as though it were stated orally by the witness who has given the evidence, provided that each witness shall be present at the hearing at which the prefiled written testimony is offered, shall adopt the written testimony under oath and shall be available for cross examination as directed by the presiding officer. Prior to its admission such written testimony shall be subject to objections by parties.

(f) **Improper conduct.** The presiding officer may exclude from the hearing room or

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from further participation in the proceedings any person who engages in improper conduct during the hearing.

(g) Nothing in sections 19a-9-1 through 19a-9-29 of the Regulations of Connecticut State Agencies shall be construed as limiting the ability of the presiding officer to make such orders as will aid in the just, economic, and efficient resolution of a case.

(h) Unless otherwise ordered by the presiding officer, any party who wishes to challenge a proposed final decision under section 4-179 of the Connecticut General Statutes shall file exceptions or a brief or request oral argument, within twenty-one (21) days of the mailing of the decision. Any party who wishes to present a brief or requests oral argument in support of a proposed final decision shall do so within thirty-five (35) days of the mailing of the decision.

(Adopted effective September 4, 1997)

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Evaluation of Candidates with Previous Licensure

Sec. 19a-14-1. Application for licensure after license has become void

A person previously licensed in Connecticut whose license has become void pursuant to section 19a-88 of the Connecticut General Statutes, may apply for licensure under the terms of these regulations. In determining the qualifications of such a candidate, pursuant to section 19a-14 of the Connecticut General Statutes, the Department of Health Services shall refer the application to the appropriate Board or Commission for review, evaluation, and recommendations. If no Board or Commission exists for the profession in question, the Department of Health Services may make the review and evaluation.

(Effective October 18, 1983)

Sec. 19a-14-2. Review and evaluation of applications

When reviewing and evaluating applications pursuant to section 19a-14-1 of these regulations, the Board, Commission or Department shall consider at least the following: (1) credentials presented for initial licensure; (2) length of practice as a licensed professional; (3) time elapsed since leaving active practice; (4) whether the candidate had been the subject of complaints, investigations or disciplinary actions as a licensed professional; and (5) any continuing education undertaken by the candidate. The Board, Commission or Department must determine whether or not these factors, taken together, meet current licensure requirements.

(Effective October 18, 1983)

Sec. 19a-14-3. Recommendations regarding acceptability

After completion of the review prescribed in section 19a-14-2 of these regulations, the Board or Commission shall make recommendations to the Department regarding the acceptability for licensure of the candidate. At its discretion, the Department may, after considering all licensure requirements and the recommendations of the Board or Commission, grant licensure to the candidate.

(Effective October 18, 1983)

Sec. 19a-14-4. License shall not be issued until or unless complaint resolved

No license shall be issued if there is a complaint awaiting adjudication against the applicant in another state or with the Department of Health Services until such a time as it is resolved in favor of the candidate.

(Effective October 18, 1983)

Sec. 19a-14-5. Suspended or revoked license

An applicant whose license has been suspended or revoked pursuant to section 19a-17 of the Connecticut General Statutes cannot reapply for licensure under the terms of these

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(Effective October 18, 1983)

Approval of Educational Programs for Candidates for Licensure

Sec. 19a-14-6—19a-14-19, inclusive. Reserved

Reserved.

Sec. 19a-14-20. Approval of educational programs

Whenever a Board or Commission identified in Section 19a-14 of the Connecticut General Statutes is authorized to approve, with the consent of the Commissioner of Health Services, educational programs for candidates for licensure, the following procedure shall apply.

The process of approval shall require the Board or Commission to provide the Department of Health Services with a written statement of the approved educational program. The Department shall provide a written response acknowledging receipt of the approved program and noting either consent or refusal of the program. The approved program and an affirmative response from the Department shall be incorporated into the formal minutes of the Board or Commission.

An agreement between the Department and a Board or Commission regarding educational programs shall remain in effect until such time as both parties have a new agreement regarding this matter.

(Effective April 9, 1984)

Prescribing and Administering Examinations for Health Care Professionals

Sec. 19a-14-21—19a-14-29, inclusive. Reserved

Reserved.

Sec. 19a-14-30. Prescribing examinations and scores

Pursuant to provisions of the Connecticut General Statutes, the Department of Health Services may prescribe licensing examinations and their passing scores for given professions with the consent of certain Boards and Commissions identified in Section 19a-14 of the General Statutes.

The process of prescribing shall require the Department of Health Services to provide the Board or Commission with a written description of the prescribed examination and passing score. Receipt of this documentation by a board must be noted in the minutes of the next formal Board or Commission meeting. These minutes should also indicate the response of the Board or Commission, i.e., consent or refusal of use of the examination and passing score.

(Effective April 9, 1984)

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Sec. 19a-14-31. Agreement of parties

An agreement between the Department and a Board or Commission regarding examinations and passing scores shall remain in effect until such time as both parties have a new agreement regarding these matters.

(Effective April 9, 1984)

Sec. 19a-14-32. Administration of examinations

The Department of Health Services shall administer all examinations under the supervision of the respective Board or Commission. The administration process shall include, but not be limited to, scheduling the examination, finding a suitable site and obtaining and training proctors and/or examiners. The Board or Commission may exercise its authority to supervise by monitoring examination administrations in order to ensure compliance with the agreed upon content and format of the examination and to ensure that all examinations are administered in a fair and secure manner.

(Effective April 9, 1984)

Sec. 19a-14-33—19a-14-39. Reserved

Medical Records

Sec. 19a-14-40. Medical records, definition, purpose

The purpose of a medical record is to provide a vehicle for: documenting actions taken in patient management; documenting patient progress; providing meaningful medical information to other practitioners should the patient transfer to a new provider or should the provider be unavailable for some reason. A medical record shall include, but not be limited to, information sufficient to justify any diagnosis and treatment rendered, dates of treatment, actions taken by non-licensed persons when ordered or authorized by the provider; doctors' orders, nurses notes and charts, birth certificate worksheets, and any other diagnostic data or documents specified in the rules and regulations. All entries must be signed by the person responsible for them.

(Effective August 29, 1984)

Sec. 19a-14-41. Professions involved

Each person licensed or certified pursuant to the following chapters and Acts shall maintain appropriate medical records of the assessment, diagnosis, and course of treatment provided each patient, and such medical records shall be kept for the period prescribed: chapters 334b, 370 thru 373, 375, 376, 378 thru 381, 383 thru 384, 388, 398, 399, and Public Acts 83-352 and 83-441.

(Effective August 29, 1984)

Sec. 19a-14-42. Retention schedule

Unless specified otherwise herein, all parts of a medical record shall be retained for a

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period of seven (7) years from the last date of treatment, or, upon the death of the patient, for three (3) years.

(a) **Pathology Slides, EEG and ECG Tracings** must each be kept for seven (7) years. If an ECG is taken and the results are unchanged from a previous ECG, then only the most recent results need be retained. Reports on each of these must be kept for the duration of the medical record.

(b) **Lab Reports and PKU Reports** must be kept for at least five (5) years. Only positive (abnormal) lab results need be retained.

(c) **X-Ray Films** must be kept for three (3) years.

(Effective August 29, 1984)

Sec. 19a-14-43. Exceptions

Nothing in these regulations shall prevent a practitioner from retaining records longer than the prescribed minimum. When medical records for a patient are retained by a health care facility or organization, the individual practitioner shall not be required to maintain duplicate records and the retention schedules of the facility or organization shall apply to the records. If a claim of malpractice, unprofessional conduct, or negligence with respect to a particular patient has been made, or if litigation has been commenced, then all records for that patient must be retained until the matter is resolved. A consulting health care provider need not retain records if they are sent to the referring provider, who must retain them. If a patient requests his records to be transferred to another provider who then becomes the primary provider to the patient, then the first provider is no longer required to retain that patient's records.

(Effective August 29, 1984)

Sec. 19a-14-44. Discontinuance of practice

Upon the death or retirement of a practitioner, it shall be the responsibility of the practitioner or surviving responsible relative or executor to inform patients. This must be done by placing a notice in a daily local newspaper published in the community which is the prime locus of the practice. This notice shall be no less than two columns wide and no less than two inches in height. The notice shall appear twice, seven days apart. In addition, an individual letter is to be sent to each patient seen within the three years preceding the date of discontinuance of the practice. Medical records of all patients must be retained for at least sixty days following both the public and private notice to patients.

(Effective August 29, 1984)

Utilization of Controlled Substances by Health Care Professionals

Sec. 19a-14-45—19a-14-49. Reserved

Sec. 19a-14-50. Definitions

For the purposes of these regulations, "Doctor" means either a physician licensed

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pursuant to Chapter 370 of the Connecticut General Statutes or an Optometrist licensed pursuant to Chapter 380 of the Connecticut General Statutes.

(Effective August 29, 1986)

Sec. 19a-14-51. Optician record retention

For each client fitted with prescription eyeglasses or prescribed contact lenses, a licensed optician shall keep a record. When prescription items are dispensed by a registered apprentice optician, the supervising licensed optician must verify the accuracy of all the data included in the client record and indicate this on the record. A client record shall contain the following:

(a) Prescription Eyewear

Records shall include:

- (1) Doctor's prescription and date, including name of prescribing doctor;
- (2) Date of delivering said prescription, to include any duplication of existing lenses;
- (3) Facial measurements, to include but not be limited to: interpupillary measures; frame size determinations, including eye size, bridge size, temple length;
- (4) Name of frame provided; and
- (5) Lens description to include: lens materials; placement of optical centers; lens tint; and, when applicable, multifocal type and placement of multifocal.

(b) Contact Lenses Prefit

(1) Prefitting record shall include: date of client visit; doctor's written prescription; doctor's keratometric measures if such measures are provided, and such other measures or observations which are properly within the optician's scope of practice as defined by Connecticut General Statutes Section 20-139;

- (2) Any information which would contraindicate the fitting of contact lenses;
- (3) The date of the examining doctor's prescription;
- (4) A prefitting biomicroscopic record of the external eye made by the doctor, if such is provided; and
- (5) Any notice provided to the client regarding the length of time after which the prescription will not be refilled.

(c) Contact Lens Dispensing

Records on the dispensing of contact lenses shall include:

- (1) All particular lens parameters including manufacturer;
- (2) Date of client instruction in handling and hygiene;
- (3) Visual acuity recorded with dispensed contact lenses as obtained by use of a standardized snellen-type chart;
- (4) If performed, a summary of observations of the physical relationship between dispensed contact lens and cornea, including, but not limited to, biomicroscopic observations;
- (5) A recommended wearing schedule; and
- (6) A summary of recommended follow-up.

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(d) Contact Lens Follow-up

Records of visits subsequent to the actual dispensing of contact lenses shall include:

- (1) Date of each visit;
- (2) Client's current wearing schedule;
- (3) Visual acuity recorded with dispensed contact lenses, obtained by use of a standardized snellen-type chart;
- (4) Date of next recommended visit; and
- (5) A description of any perceived changes in visual acuity or obvious anomalies, and a record of any report made to the client or prescribing doctor.

(Effective August 29, 1986)

Sec. 19a-14-52—19a-14-54. Reserved

Sec. 19a-14-55. Utilization of controlled substances

Those health care practitioners identified in Section 19a-14 of the Connecticut General Statutes and regulated by the Department of Health Services who utilize controlled substances shall be subject to disciplinary action, as set forth in Section 19a-17 of the Connecticut General Statutes, if they utilize or store drugs in a manner which is not consistent with the public interest. In determining the public interest, the following factors shall be considered:

- (a) Maintenance of effective controls against diversion of controlled substances into other than duly authorized legitimate medical, scientific, or commercial channels;
- (b) Compliance with all applicable state and federal laws and regulations concerning controlled substances;
- (c) Any conviction of the practitioner under any state or federal law relating to controlled substances;
- (d) Expiration, suspension, revocation, surrender or denial of the practitioner's federal controlled substance registration;
- (e) Prescribing, distributing, administering or dispensing of controlled substances in schedules other than those specified in the practitioner's state or federal registration.

(Effective April 9, 1984)

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Conditions for Physician Participation in the Malpractice Insurance Purchase Program

Sec. 19a-17n-1. Definitions (Repealed)

Repealed June 11, 2014.

(Adopted effective July 25, 1997; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-17n-2. Conditions for physician participation (Repealed)

Repealed June 11, 2014.

(Adopted effective July 25, 1997; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

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Disclosure of Health Data

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Disclosure of Health Data

Sec. 19a-25-1. Definitions

As used in Sections 19a-25-1 through 19a-25-4, inclusive, of the Regulations of Connecticut State Agencies:

(1) “Aggregate health data” means health data that is obtained by combining like data in a manner that precludes the identification of the individual or organization supplying the data or described in the data.

(2) “Anonymous medical case history” means the description of an individual’s illness in a manner that precludes the identification of the individual or organization supplying the data or described in the data.

(3) “Commissioner” means the commissioner of the Department of Public Health.

(4) “Department” means the Department of Public Health.

(5) “Disclosure” or “disclose” means the communication of health data to any individual or organization outside the department.

(6) “Health data” means information, recorded in any form or medium, that relates to the health status of individuals, the determinants of health and health hazards, the availability of health resources and services, or the use and cost of such resources and services.

(7) “Identifiable health data” means any item, collection, or grouping of health data that makes the individual or organization supplying it, or described in it, identifiable.

(8) “Individual” means a natural person.

(9) “Local Director of Health” means the city, town, borough, or district Director of Health or any person legally authorized to act for the local director of health.

(10) “Medical or scientific research” means the performance of activities relating to health data, including, but not limited to:

(A) describing the group characteristics of individuals or organizations;

(B) characterizing the determinants of health and health hazards;

(C) analyzing the inter-relationships among the various characteristics of individuals or organizations;

(D) the preparation and publication of reports describing these matters; and

(E) other related functions as determined by the commissioner.

(11) “Organization” means any corporation, association, partnership, agency, department, unit, or other legally constituted institution or entity, or part thereof.

(12) “Studies of morbidity and mortality” means the collection, application, and maintenance of health data on:

(A) the extent, nature, and impact of illness and disability on the population of the state or any portion thereof;

(B) the determinants of health and health hazards, including but limited to,

(i) infectious agents of disease,

(ii) environmental toxins or hazards,

(iii) health resources, including the extent of available manpower and resources, or

(iv) the supply, cost, financing or utilization of health care services.

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(C) diseases on the commissioner's list of reportable diseases and laboratory findings pursuant to section 19a-215 of the Connecticut General Statutes; or

(D) similar health or health related matters as determined by the commissioner.

(Adopted effective October 30, 1998)

Sec. 19a-25-2. Disclosure of aggregate health data, anonymous medical case histories, and reports of the findings of studies of morbidity and mortality

(a) The department may, at the discretion of the commissioner, publish, make available, and disseminate aggregate health data, anonymous medical case histories, and reports of the findings of studies of morbidity and mortality, provided such data, histories, and reports:

(1) Are prepared for the purpose of medical and scientific research; and

(2) Do not include identifiable health data.

(b) No individual or organization with lawful access to such reports shall be compelled to testify with regard to such reports. Publication or release of such reports shall not subject said report or related information to subpoena or similar compulsory process in any civil or criminal, judicial, administrative or legislative proceeding.

(Adopted effective October 30, 1998)

Sec. 19a-25-3. Disclosure of identifiable health data

(a) The department shall not disclose identifiable health data unless:

(1) The disclosure is to health care providers in a medical emergency as necessary to protect the health, life, or well-being of the person with a reportable disease or condition pursuant to section 19a-215 of the Connecticut General Statutes;

(2) The disclosure is to health care providers, the local director of health, the department, another state or public health agency, including those in other states and the federal government, or other persons when deemed necessary by the department in its sole discretion for disease prevention and control pursuant to section 19a-215 of the Connecticut General Statutes or for the purpose of reducing morbidity and mortality from any cause or condition, except that every effort shall be made to limit the disclosure of identifiable health data to the minimal amount necessary to accomplish the public health purpose;

(3) The disclosure is to an individual, organization, governmental entity in this or another state or to the federal government, provided the department determines that:

(A) Based upon a written application and such other information as required by the department to be submitted by the requesting individual, organization or governmental entity the data will be used solely for bona fide medical and scientific research;

(B) The disclosure of data to the requesting individual, organization or governmental entity is required for the medical or scientific research proposed;

(C) The requesting individual, organization, or governmental entity has entered into a written agreement satisfactory to the department agreeing to protect such data in accordance with the requirements of this section and not permit disclosure without prior approval of the department; and

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(D) The requesting individual, organization or governmental entity, upon request of the department or after a specified date or event, returns or destroys all identifiable health data provided by the department and copies thereof in any form.

(4) The disclosure is to a governmental entity for the purpose of conducting an audit, evaluation, or investigation required by law of the department and such governmental entity agrees not to use such data for making any determination as to whom the health data relates.

(b) Any disclosure provided for in this section shall be made at the discretion of the department, provided the requirements for disclosure set forth in the applicable provisions of this section have been met. For disclosures under this section to governmental entities, the commissioner may waive the requirements of this section except for the requirements of subdivision (A) of subsection (3).

(c) Notwithstanding any other provisions of this section, no identifiable health data obtained in the course of activities undertaken or supported under this section shall be subject to subpoena or similar compulsory process in any civil or criminal, judicial, administrative, or legislative proceeding, nor shall any individual or organization with lawful access to identifiable health data under the provisions of this section be compelled to testify with regard to such health data.

(Adopted effective October 30, 1998)

Sec. 19a-25-4. Use of health data for enforcement purposes

(a) Notwithstanding any provisions of sections 19a-25-1 to 19a-25-3, inclusive of the Regulations of State Agencies, the department may utilize, in any manner, health data including but not limited to aggregate health data, identifiable health data, and studies of morbidity and mortality, in carrying out and performing its statutory and regulatory responsibilities and to secure compliance with or enforcement of any laws. Where such data is used in an enforcement action brought by the department or any other state agency, disclosure to parties to the action of such data shall be permitted only if required by law and said parties may not further disclose such data except to a tribunal, administrative agency or court with jurisdiction over the enforcement action. Disclosure under this section does not constitute a waiver or release of the confidentiality that protects such data.

(Adopted effective October 30, 1998)

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Agency

Department of Public Health and Addiction Services

Subject

AIDS Research Education Fund

Inclusive Sections

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Sec. 19a-32a-4.	Grant application procedures
Sec. 19a-32a-5.	Review of applications for funding

AIDS Research Education Fund

Sec. 19a-32a-1. AIDS research grants

(a) Any person, municipality, public agency, private for profit or non-profit private agency may apply for funds for AIDS-related research projects that contribute to:

- (1) preventing human immunodeficiency virus (HIV) infection, or
- (2) improving delivery of care to people with HIV/AIDS, or
- (3) improving treatment of people with HIV/AIDS, or
- (4) understanding the needs of people with HIV/AIDS, or
- (5) evaluating prevention or treatment programs or modalities.

(Effective August 24, 1994)

Sec. 19a-32a-2. AIDS education and related community service

Any person, municipality, public agency, or private for profit or non-profit private agency may apply for funds to provide educational interventions for populations affected by HIV/AIDS or to provide community services to persons suffering from HIV/AIDS and to the families and partners of such persons. Such services shall include but not necessarily be limited to:

- (a) outreach,
- (b) education,
- (c) counseling,
- (d) testing,
- (e) case management,
- (f) social services, and
- (g) transportation.

(Effective August 24, 1994)

Sec. 19a-32a-3. Promotion of the contribution system and the AIDS research education fund account

Any person, municipality, public agency, private for profit or non-profit private agency may apply for funds to promote the income tax contribution system and the AIDS research education fund account.

(Effective August 24, 1994)

Sec. 19a-32a-4. Grant application procedures

The commissioner shall issue requests for proposals for funds pursuant to sections 19a-32a-1 through 19a-32a-3 of the Regulations of Connecticut State Agencies by November 15 of each year. These requests for proposals shall contain the criteria to be used in evaluating the proposals. Applications for funds shall be submitted in writing to the commissioner in the form prescribed by the commissioner.

(Effective August 24, 1994)

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Sec. 19a-32a-5. Review of applications for funding

The commissioner shall evaluate all proposals for funds with the advice of an ad hoc review committee. This review committee shall include persons who are infected with HIV. It shall also include expertise the funding areas for which the request for proposal has been issued. No person on the review committee, or such person's family, shall be in a position to realize any financial gain from the awarding of such grant.

(Effective August 24, 1994)

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Subject

Breast Cancer Research and Education Fund

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Sec. 19a-32b-2.	Breast cancer education and related community service
Sec. 19a-32b-3.	Promotion of the contribution system and the breast cancer research and education fund account (Repealed)
Sec. 19a-32b-4.	Grant application procedures (Repealed)
Sec. 19a-32b-5.	Review of applications for funding (Repealed)

Breast Cancer Research and Education Fund

Sec. 19a-32b-1. Breast cancer research grants

Any person, municipality, public agency, private for profit or non-profit private agency may apply for funds for breast cancer-related research projects that contribute to:

- (1) preventing breast cancer, or
- (2) improving delivery of care to people with breast cancer, or
- (3) improving treatment of people with breast cancer, or
- (4) understanding the needs of people with breast cancer, or
- (5) evaluating prevention or treatment programs or modalities.

(Adopted effective August 31, 1998)

Sec. 19a-32b-2. Breast cancer education and related community service

Any person, municipality, public agency, private for profit or non-profit private agency may apply for funds to provide educational interventions for populations affected by breast cancer or to provide community services to persons suffering from breast cancer and to the families of such persons. Such services shall include but not necessarily be limited to:

- (a) outreach,
- (b) education,
- (c) counseling,
- (d) testing,
- (e) case management,
- (f) social services, and
- (g) transportation.

(Adopted effective August 31, 1998)

Sec. 19a-32b-3. Promotion of the contribution system and the breast cancer research and education fund account (Repealed)

Repealed June 11, 2014.

(Adopted effective August 31, 1998; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-32b-4. Grant application procedures (Repealed)

Repealed June 11, 2014.

(Adopted effective August 31, 1998; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

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Sec. 19a-32b-5. Review of applications for funding (Repealed)

Repealed June 11, 2014.

(Adopted effective August 31, 1998; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

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Subject

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Inclusive Sections

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Sec. 19a-36-A2.	List of reportable diseases and laboratory findings
Sec. 19a-36-A3.	Persons required to report reportable diseases and laboratory findings
Sec. 19a-36-A4.	Content of report and reporting of reportable diseases and laboratory findings
Sec. 19a-36-A5.	Confidentiality of data
Sec. 19a-36-A6.	Investigation and control of reportable disease and outbreaks by the department
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Reportable Diseases and Laboratory Findings

Sec. 19a-36-A1. Definitions

As used in Sections 19a-36-A1 to 19a-36-A55:

(a) “Authorized agent” means an individual designated by a local director of health to act for him or her in the performance of any of his or her duties.

(b) “Carrier” means an infected person or animal who, without any apparent symptoms of communicable disease, harbors a specific infectious agent and may serve as a source of infection for humans. The state of harboring a specific infectious agent may occur in an individual with an infection that is inapparent throughout its course (asymptomatic carrier), or in an individual during the incubation period, convalescence, and post-convalescence of a clinically recognizable disease (incubatory carrier and convalescent carrier). The carrier state may be of short duration (transient carrier) or long duration (chronic carrier).

(c) “Case” means a person or animal who exhibits evidence of disease.

(d) “Cleaning” means the process of removal of organic matter conducive to growth or maintenance of infectivity of infectious agents by scrubbing and washing as with hot water and soap.

(e) “Commissioner” means the state commissioner of health services.

(f) “Communicable disease” means a disease or condition, the infectious agent of which may pass or be carried directly or indirectly, from the body of one person or animal to the body of another person or animal.

(g) “Communicable period” means any time period during which a specific infectious agent may be transferred directly or indirectly from an infected person or animal to another human or animal.

(h) “Contact” means a person or animal known to have had association with an infected person or animal in such a manner as to have been exposed to a particular communicable disease.

(i) “Contamination” means the presence of undesirable substance or material which may contain an infectious agent on external body surfaces (e.g., skin), articles of apparel, inanimate surfaces or in food or beverages.

(j) “Cultures” mean growths of an infectious agent propagated on selected living or artificial media.

(k) “Date of onset” means the day, month and year on which the case or suspected case experienced the first sign or symptoms of the disease.

(l) “Department” means the Connecticut Department of Health Services.

(m) “Disinfection” means a directly applied chemical or physical process by which the disease producing powers of infectious agents are destroyed. (1) “Concurrent disinfection” means the immediate disinfection and disposal of body discharges, and the immediate disinfection or destruction of all infected or presumably infected materials. (2) “Terminal disinfection” means the process of rendering the personal clothing and immediate physical environment of a patient free from the probability of conveying an infectious agent to others after removal of the patient or at a time when the patient is no longer a source of infection.

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(n) “Epidemic” means the occurrence of cases of illness clearly in excess of normal expectancy over a specific time period in a community, geographic region, building or institution. The number of cases indicating an epidemic may vary according to the causative agent, size and type of population exposed, previous experience with the disease, and time and place of occurrence. An outbreak of disease is an epidemic.

(o) “Epidemiologic investigation” means an inquiry into the incidence, distribution and source of disease to determine its cause, means of prevention, and efficacy of control measures.

(p) “Foodborne outbreaks” means illness in two or more individuals acquired through the ingestion of common-source food or water contaminated with chemicals, infectious agents or their toxic products. Foodborne outbreaks include, but are not limited to, illness due to heavy metal intoxications, staphylococcal food poisoning, botulism, salmonellosis, shigellosis, *Clostridium perfringens* intoxication and hepatitis A.

(q) “Foodhandler” means a person who prepares, processes, or otherwise handles food or beverages for people other than members of his or her immediate household.

(r) “Health care facility” means any hospital, long term care facility, home health care agency, clinic or other institution licensed under Chapter 368v of the Connecticut General Statutes and also facilities operated and maintained by any state agency for the care or treatment of mentally ill persons or persons with mental retardation or substance abuse problems.

(s) “Health care provider” means a person who has direct or supervisory responsibility for the delivery of health care or medical services. This shall include but not be limited to: licensed physicians, nurse practitioners, physician assistants, nurses, dentists, medical examiners, and administrators, superintendents and managers of health care facilities.

(t) “Incubation period” means the time interval between exposure to a disease organism and the appearance of the first symptoms of the resulting disease.

(u) “Infection” means the entry and multiplication of an infectious agent in the body of a person or animal with or without clinical symptoms.

(v) “Infectious agent” means a microorganism capable of producing infection with or without disease.

(w) “Isolation” means the use of special precautions during the period of communicability to prevent transmission of an infectious agent. Such special precautions may include: physical separation of infected persons or animals from others, or precautions such as blood precautions that do not necessarily result in physical separation of individuals.

(x) “Laboratory” means any facility licensed, or approved by the department in accordance with section 19a-30 of the Connecticut General Statutes.

(y) “Local director of health” means and includes the city, town, borough or district director of health and any person legally authorized to act for the local director of health.

(z) “Medical information” means the recorded health information on an individual who has a reportable disease or who has symptoms of illness in the setting of an outbreak. This information includes details of a medical history, physical examination, any laboratory test,

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diagnosis, treatment, outcome and the description and sources of suspected causative agents for such disease or illness.

(aa) “Nosocomial infection” means infections that develop within a hospital or other health care facility or are produced by microorganisms acquired while in a hospital or health care facility.

(bb) “Outbreak.” See “epidemic.”

(cc) “Quarantine” means the formal limitation of freedom of movement of persons or animals exposed to, or suffering from a reportable disease for a period of time not longer than either the longest incubation period or the longest communicable period of the disease, in order to prevent spread of the infectious agent of that disease.

(dd) “Reportable disease” means a communicable disease, disease outbreak, or other condition of public health significance required to be reported to the department and local health directors.

(ee) “Reportable laboratory finding” means a laboratory result suggesting the presence of a communicable disease or other condition of public health significance required to be reported to the department and local health directors.

(ff) “State epidemiologist” means the person designated by the Commissioner as the person in charge of communicable disease control for the state.

(gg) “Surveillance” means the continuing scrutiny of all aspects of occurrence and spread of a disease relating to effective control of that disease, which may include but not be limited to the collection and evaluation of: morbidity and mortality reports; laboratory reports of significant findings; special reports of field investigations of epidemics and individual cases; data concerning the availability, use, and untoward side effects of the substances used in disease control, such as rabies vaccine; and information regarding immunity levels in segments of the population.

(hh) “Suspected case” means a person or animal suspected of having a particular disease in the temporary or permanent absence of definitive clinical or laboratory evidence.

(ii) “Other condition of public health significance” means a non-communicable disease caused by a common source or prevalent exposure such as pesticide poisoning, silicosis or lead poisoning.

(Effective October 25, 1989; Amended October 10, 2008)

Sec. 19a-36-A2. List of reportable diseases and laboratory findings

The commissioner shall issue a list of reportable diseases and laboratory findings within sixty days of the effective date of these regulations, on the next January 1, and annually thereafter. The list shall show it is the current list and shall specify its effective date. This list shall also include but not be limited to the reporting category of each disease, procedures for the reporting, and minimum investigation and control measures for each disease. Listed diseases are declared reportable diseases as of the effective date of approval by the commissioner.

(a) The commissioner in consultation with the state epidemiologist will annually review

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the existing list and develop recommendations for deletions or additions to the list.

(b) The state epidemiologist or other commissioner designee shall convene and chair an advisory committee to review the recommendations for any changes to the list prior to preparing the final list for that year. This committee shall make recommendations to the commissioner regarding the contents of the list.

(c) The commissioner shall review the advisory committee's recommendations and make final deletions or additions to the list to take effect January 1 of the next year. He will furnish copies of the list before January 1 to the following:

- (1) physicians licensed by the department;
- (2) directors of clinical laboratories licensed, registered or approved by the department;
- (3) local directors of health in Connecticut;
- (4) health care facilities licensed under Chapter 368v of the Connecticut General Statutes.

(Effective October 25, 1989)

Sec. 19a-36-A3. Persons required to report reportable diseases and laboratory findings

(a) Reportable Diseases.

(1) Every health care provider who treats or examines any person who has or is suspected to have a reportable disease shall report to the local director of health or other health authority within whose jurisdiction the patient resides and to the department such information about the affected person as described in section 19a-36-A4 of these regulations.

(2) If the case or suspected case of reportable disease is in a health care facility, the person in charge of such facility shall ensure that reports are made to the local director of health and the department in the manner specified in section 19a-36-A4 of these regulations. The person in charge shall designate appropriate infection control or record-keeping personnel for this purpose.

(3) If the case or suspected case of reportable disease is not in a health care facility and if a health care provider is not in attendance or is not known to have made a report within the appropriate time specified in section 19a-36-A4, such report of reportable diseases shall be made to the local director of health or other health authority within whose jurisdiction the patient lives and the department in the manner specified in section 19a-36-A4 by:

(A) the administrator serving a public or private school or day care center attended by any person affected or apparently affected with such disease;

(B) the person in charge of any camp;

(C) the master or any other person in charge of any vessel lying within the jurisdiction of the state;

(D) the master or any other person in charge of any aircraft landing within the jurisdiction of the state;

(E) the owner or person in charge of any establishment producing, handling or processing dairy products, other food or non-alcoholic beverages for sale or distribution;

(F) morticians and funeral directors.

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(4) Each local director of health shall report or ensure reporting to the department within 24 hours of each case or suspected case of a Category I reportable disease and such additional information of which he has knowledge as described in section 19a-36-A4 of these regulations.

(b) **Reportable laboratory findings.**—The director of a laboratory that receives a primary specimen or sample which yields a reportable laboratory finding shall be responsible for reporting such findings within forty-eight (48) hours to the local director of health of the town in which the affected person normally resides, or, in the absence of such information, of the town from which the specimen originated, and to the department on forms provided by the department.

(1) When a laboratory identifies or presumptively identifies a significant isolate or other finding that requires confirmation by the laboratory as required in the annual list, the director must submit that isolate or specimen from which the finding was made to the department's laboratory division.

(2) Laboratory tests and confirmatory tests for certain reportable diseases as specially indicated in the annual list shall be exempted from any and all fees for the state laboratory services in accordance with Section 19a-26 of the Connecticut General Statutes.

(Effective October 25, 1989)

Sec. 19a-36-A4. Content of report and reporting of reportable diseases and laboratory findings

(a) Reportable diseases.

(1) Each report of a case or suspected case of reportable disease shall include the full name and address of the person reporting and of the physician attending; the diagnosed or suspected disease and date of onset; the full name, age, race/ethnicity, sex and occupation of the affected individual and other facts the department or local director of health requires for purposes of surveillance, control and prevention of reportable diseases. The reports shall be sent in envelopes marked "CONFIDENTIAL."

(2) Reports may be written or oral as required by the category of disease as follows:

(A) Category I: diseases of high priority because of need for timely public health action: reportable immediately by telephone on day of recognition or suspicion of disease; on weekdays to both, the local health director of the town in which the patient resides and the department, on weekends to the department. A completed disease report form provided by the department must also be mailed to both the local health director and the department within 12 hours.

(B) Category II: diseases of significant public health importance, usually requiring public health action: reportable by mail to the local director health and the department within 12 hours of recognition or suspicion on a form provided by the department.

(b) Reportable laboratory findings.

(1) Each report of reportable findings shall include the name, address, age, sex, and, if known, race/ethnicity of the person affected, the name and address of the attending

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physician, the identity of the infectious agent or other reportable laboratory findings, and the method of identification.

(2) Reports shall be mailed to the local director of health of the town in which the patient resides and to the department within 48 hours of making the finding in envelopes marked "CONFIDENTIAL."

(Effective October 25, 1989)

Sec. 19a-36-A5. Confidentiality of data

All epidemiologic information which identifies an individual and which is gathered by the state or local health department in connection with the investigation of reported cases or suspected cases of disease or during the investigation of outbreaks of disease shall be kept in compliance with current confidentiality statutes.

(Effective October 25, 1989)

Sec. 19a-36-A6. Investigation and control of reportable disease and outbreaks by the department

(a) The department, in cooperation with the local director of health, in the investigation and control of reportable disease shall make or cause to be made such investigation as it deems necessary and shall secure all such data as may assist it in establishing adequate control measures.

(b) In order to investigate and control any apparent outbreak or unusual occurrence of reportable disease, the department shall institute such special disease surveillance, follow-up reports and control measures as it deems necessary.

(c) Individual medical information pertaining to cases of reportable disease, persons affected by outbreaks of disease or significant increases in the rate of nonsocomial infection shall be provided when requested to an investigator who presents official identification of the department or the local department of health. Such an investigator may be an employee of the State or local health department.

(Effective October 25, 1989)

Sec. 19a-36-A7. Diseases not enumerated

Diseases not specifically listed pursuant to section 19a-36-A2 and presenting a special problem shall be reported and controlled in accordance with special instructions of the state department of health or, in the absence of such instructions, in accordance with orders and directions of the local director of health.

(Effective October 25, 1989)

Sec. 19a-36-A8. General measures for control of reportable diseases

The local director of health, in instituting measures for the control of reportable diseases:
Investigation

(a) shall make, or cause to be made, such investigations as he may deem necessary and

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shall secure all such data as may assist him in establishing adequate control measures;

Isolation and orders

(b) shall establish and maintain quarantine, isolation or such other measures for control as are required by statute, the public health code or special instructions of the state department of health, and, when possible, shall issue his instructions and orders in writing or on printed forms;

Removal

(c) shall have the authority to set up proper isolation or quarantine of an affected person or persons, carrier or contact, when, in his opinion or in the opinion of the state commissioner of health, this is not or cannot be effectively maintained on the premises occupied by such person or persons by methods designated in this part; to remove or require the removal of such person or persons to a hospital or other proper place designated by him; or to employ such guards or officers as may be necessary to maintain effective isolation or quarantine;

Instruction

(d) shall provide, by himself or his authorized agent, for the specific instruction of cases, contacts, their attendants and all other persons affected, in the proper methods for the prevention of the spread of the disease and shall supply such information and literature as may be required by law or by the instructions of the state department of health;

Enforcement

(e) shall make, at intervals during the period of communicability, inquiry or investigation to satisfy himself that the measures instituted by him for the protection of others are being properly observed;

Laboratory tests

(f) shall, when the control or release of a case, contact or carrier of a reportable disease is dependent upon laboratory findings, require the specimens upon which such findings are based to be examined by the laboratory division of the state department of health or by a laboratory specifically approved for that purpose by the state department of health and shall, by himself or his authorized agent, secure and submit release cultures or specimens for examination; in cases of enteric diseases all release specimens shall be taken at least one week after specific therapy has been discontinued;

Schools—Isolation

(g) shall, in the event of an outbreak of a communicable disease in any public, private, parochial or church school, make a prompt and thorough investigation; control such an outbreak by individual examination of pupils, teachers and other persons associated with the outbreak; employ such other means as he deems necessary to determine the source of infection or to provide for the segregation of infected persons; in the event of an outbreak of a communicable disease in any school, require school physicians and school nurses to conform to the orders, regulations and restrictions issued by him;

Schools—Readmission

(h) shall, in the case of any school child who has been excluded from school for having

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been a case, contact or carrier of a communicable disease, by himself or his authorized agent, issue a permit for such child to re-enter school when in his opinion such child is no longer infectious;

Unusual disease

(i) shall, when an unusual or rare disease occurs in any part of the state or when any disease becomes so prevalent as to endanger the state as a whole, contact the state department of health for assistance, and shall cooperate with the representatives of the state department of health acting under the direction of the state commissioner of health;

Other measures

(j) shall introduce such other measures as he may deem advisable.

(Effective October 25, 1989)

Sec. 19a-36-A9. Control of diseases suspected of being reportable

The local director of health, on receiving a report of a disease suspected of being reportable, shall confer with the physician or other person making such report, make further examination or investigation as he deems necessary and advise, recommend or establish such procedures as he may deem necessary to protect the public health until the character of the disease is definitely determined.

(Effective October 25, 1989)

Sec. 19a-36-A10. Presumably exposed persons may be examined and controlled

The local director of health, when he has reasonable grounds to believe that a person or persons may have been exposed to a communicable disease, may control such persons as known contacts and may make such examinations and adopt such measures as he deems necessary and proper for the protection of the public health and the prevention of the spread of disease.

(1) The conviction of any person for any offense involving sexual promiscuity or illicit sex relations shall constitute reasonable grounds for the local director of health to believe that that person may have been exposed to a communicable disease and shall justify the examination and such other measures of control of that individual as are deemed necessary and proper by the state department of health for the protection of public health and the prevention of spreading of disease.

(2) The warden or other person in charge of any prison or jail in the state shall notify the prison or jail physician, in writing, within twenty-four hours upon the receipt of a prisoner who may have been exposed to a communicable disease and of every prisoner who has been convicted of any offense involving sexual promiscuity or illicit sex relations. A routine medical examination shall be made on every prisoner whose conviction involves sexual promiscuity or illicit sex relations. Such routine medical examination shall include the taking of a blood specimen for serological test for syphilis and the taking of three smears for gonococci taken not less than twenty-four hours apart and, if the prisoner is found to be infected, treatment shall be instituted as necessary. The tests referred to above shall be

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performed in the bureau of laboratories of the state department of health or in a laboratory specifically approved for these purposes by the state department of health, and they shall be performed in a manner that meets the approval of the state department of health. Upon the expiration of a sentence, any person having syphilis or gonococcal infection, whether in an infectious or non-infectious stage, and in need of further followup treatment shall be reported to the state department of health by the attending physician, who shall give the name, sex, age and marital status and a record of the treatment given while such person was imprisoned.

(Effective October 25, 1989)

Sec. 19a-36-A11. Control of carriers of the infectious agent of communicable disease

Carriers, whether transient, convalescent or chronic, of the infectious agent of any communicable disease shall be maintained under observation until repeated laboratory examinations of appropriate specimens show the absence of the infectious agent. Examination of all such specimens shall be in conformity with subsection (f) of section 19a-36-A8.

(a) Any local director of health or physician who discovers any carrier of an infectious agent shall report the fact to the state department of health giving the full name, age, sex, occupation and address of such carrier. The state department of health shall, upon receipt of such report, notify the local director of health of the town, city or borough wherein the carrier resides. The local director of health concerned shall then communicate the fact to the carrier himself, or his guardian, giving specific instructions regarding the precautions necessary to protect others from infection.

(b) Any privy or latrine used by an enteric disease carrier shall be so constructed as to exclude flies and to meet the approval of the local director of health. The disinfection and disposal of its contents shall be in accordance with instructions given by the local director of health.

(c) A carrier of an infectious agent shall not engage in any occupation involving the handling of any food or beverage intended for the use of others.

(d) Enteric disease carriers shall not work on any public water supply or watershed.

(e) A carrier who changes his residence shall notify the local director of health of the town, city or borough in which he has been residing of the date of his departure, his destination and his new address. The local director of health shall immediately forward this information to the state department of health.

(f) The local director of health shall visit each carrier within his jurisdiction at least once every three months and shall render quarterly reports concerning each such carrier to the state department of health upon forms prescribed for the purpose.

(Effective October 25, 1989)

Sec. 19a-36-A12. Enteric disease carriers

(a) A chronic carrier of enteric disease shall be defined as a person who persists in

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excreting enteric pathogenic organisms for twelve months or more after onset of illness or probable date of infection or one who, though he may never have been known to have the disease, has been shown to harbor the infectious agent in his body.

(b) All specimens for the release of enteric carriers from supervision shall be collected at least ten days after the cessation of any antibiotic therapy or any therapy directed at the disease.

(c) All specimens for the release of enteric carriers from supervision shall be examined in conformity with subsection (f) of section 19a-36-A8.

(d) Chronic carriers of the organisms causing typhoid fever and paratyphoid fever shall not be released from supervision until six successive specimens of urine and six successive specimens of feces, the last two of which shall be validated by collection of the specimen in a hospital or otherwise under direct supervision, have been found negative. Specimens for such examination shall be so collected that a time interval of not less than one month shall elapse between successive specimens of urine and between successive specimens of feces. The final two specimens of feces to be examined may be validated by the giving of lycopodium or a negative bile culture may be substituted for such validation.

(e) A chronic carrier of enteric disease excreting the organism in discharges other than the feces or urine shall not be released from supervision until negative cultures as outlined by the state department of health for the specific case have been obtained.

(Effective October 25, 1989)

Sec. 19a-36-A13. Control of tuberculosis

(a) When a licensed physician or hospital superintendent has reported a case of tuberculosis and has agreed to assume the responsibility for the proper instruction of the patient and the taking of measures necessary for the protection of others, the local director of health need not take action other than that prescribed by sections 19a-262 to 19a-264, inclusive, of the general statutes.

(b) When such patient, while in an infectious state, neglects or refuses to follow the prescribed instructions or discontinues treatment, the physician or superintendent shall immediately notify the local director of health.

(c) When a physician or hospital superintendent has declined to assume such responsibility, the local director of health shall supply the affected person with printed instructions and take such other action as may be necessary and proper for the protection of the public health.

(Effective October 25, 1989)

Sec. 19a-36-A14. Control of refractory persons affected with tuberculosis

When it comes to the attention of a local director of health that a person is affected with tuberculosis and is a menace to the public health or is likely to jeopardize the health of any person or persons in or on the premises occupied or frequented by the affected person, he shall immediately investigate and shall take proper measures to prevent the spread of such

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disease for the protection of the public health and, if necessary, may cause the removal of such person to an isolation hospital or other proper place, there to be received and kept until he is no longer a menace to the public health.

(Effective October 25, 1989)

Sec. 19a-36-A15. Control of venereal disease

(a) When a licensed physician or hospital superintendent has reported a case of gonorrhea or syphilis and has agreed in writing to assume the responsibility for the proper instruction of the patient, the local director of health shall supply such physician or hospital superintendent with printed instructions for such patient.

(b) When such patient, while in an infectious state, neglects or refuses to follow the prescribed instructions or discontinues treatment, the physician or superintendent shall immediately notify the local director of health.

(c) In investigating cases or suspected cases of the above-mentioned diseases, the local director of health shall treat all information as confidential, but such course shall not preclude the making of reports to the state department of health.

(Effective October 25, 1989)

Sec. 19a-36-A16. Control of refractory persons affected with venereal diseases

When it comes to the attention of a local director of health that a person is affected with or presumably affected with gonorrhea or syphilis in any form and is likely to jeopardize the health of any person or persons in or on the premises occupied or frequented by the affected person, the local director of health shall immediately investigate and shall take proper measures to prevent the spread of such disease for the protection of the public health, and he shall direct such person to report regularly for treatment to a licensed physician or to a public clinic, there to be treated until such person is free from infectious discharges. If such person, in the opinion of the local director of health, is a menace to the public health, the local director of health shall order the removal of such person to an isolation hospital or other proper place, there to be received and kept until he no longer is a menace to the public health; or the local director of health shall adopt such other measures as he may deem necessary to protect the public health.

(Effective October 25, 1989)

Sec. 19a-36-A17. Observance of quarantine and instructions

Every person who is affected with a communicable disease, who is a carrier or who is suspected of having come in contact, directly or indirectly, with a case of communicable disease shall strictly observe and comply with all orders, quarantine regulations and restrictions given or imposed by the local health authority or the state commissioner of health in conformity with law.

(Effective October 25, 1989)

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Sec. 19a-36-A18. Control of quarantine area

No person other than the attending physicians and authorized attendants shall enter or leave, and no one except the local director of health or his representative shall permit any other person to enter or leave, any room, apartment or premises quarantined for a communicable disease, nor shall any person needlessly expose a child or other person to a communicable disease. No person shall remove any article from a quarantined area without permission of the local director of health. The local director of health shall report immediately to the state commissioner of health, by telegraph or telephone, the name, address, probable destination and route of departure of any person who was under control for a reportable disease and who has left his jurisdiction without his consent.

(Effective October 25, 1989)

Sec. 19a-36-A19. Duty of local director of health to quarantined persons in need

When a person under quarantine is, in the opinion of the local director of health, unable to obtain medical care, food or other actual necessities, the local director of health shall report his findings to the proper town, city or borough authority. If such town, city or borough authority fails to supply at once the needed care, the local director of health shall supply such quarantined person with medical attention, food or other actual necessities, and the expense incurred in performing such duty shall constitute a legal expense of the local director of health and shall be paid according to state statute.

(Effective October 25, 1989)

Sec. 19a-36-A20. Preventing spread of disease by common carriers

In the event of the epidemic prevalence of a communicable disease, when a written declaration to that effect has been made by the state commissioner of health, any person, firm or corporation operating any common carrier within the state, or in the waters thereof, shall comply strictly with any order issued by the state commissioner of health for the purpose of preventing the introduction into the state, or the transmission from one point to another within the state, of any person or persons, animals, insects or materials likely to convey the disease.

(Effective October 25, 1989)

Sec. 19a-36-A21. Food and food handlers restricted

When a case of any of the reportable diseases listed pursuant to section 19a-36-A2 occurs on the premises where milk or food is produced, kept, handled or sold, the local director of health shall institute such measures as he deems necessary to prevent the spread of such disease and to protect such foods from being contaminated; and he shall require all uninfected persons who reside in an apartment or dwelling where any such disease exists, and who handle milk or food elsewhere, to remain away from such abode as long as the disease is present.

(Effective October 25, 1989)

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Sec. 19a-36-A22. Use of milk, food and water containers restricted

The local director of health in charge of a case or a suspected case of a communicable disease that may be conveyed by milk, food or water shall forbid the return of any container to the distributor when such container has been within a quarantined area, or has been handled or presumably handled by anyone in attendance upon a person affected or believed to be affected with such disease, until such empty container has been sterilized by boiling water or by live steam, or in any other manner satisfactory to the local director of health.

(Effective October 25, 1989)

Sec. 19a-36-A23. Regulation of traffic in psittacine birds

(a) As used in this section: “Psittacine birds” means, unless otherwise specified, all birds commonly known as parrots, macaws, cockatoos, lovebirds, parakeets, cockatiels and all birds of the order psittaciformes.

(b) Any person or entity that imports, purchases, breeds, sells, exchanges, barter, gives away or otherwise deals in psittacine birds shall keep records of such transactions embodying information required by the Department of Public Health. For each bird, records shall include:

- (1) The date of bird’s arrival on premises;
- (2) A description of the bird (i.e.: species, common name, variety);
- (3) The unique identifier consistent with the leg band or microchip;
- (4) The name, address and phone number of the prior owner of the bird; and
- (5) The date and a description of the final disposition. If the final disposition is a change of ownership, the records shall also include name, address and phone number of the person accepting ownership of the bird.

Such records shall be open for inspection by the local director of health, a representative of the Department of Public Health, a local animal control officer, or a representative of the state Department of Agriculture. The records shall be kept for the period of time commencing on the date of the bird’s arrival on the premises and continuing until two years following the date of final disposition of such bird.

(c) Except as provided for in subsection (d) of these regulations, all psittacine birds, except parakeets, that are imported, purchased, sold, exchanged, bartered or given away shall be banded with a metal leg band that has a diameter adequate for the species. Said band shall contain a unique identifier for each individual psittacine bird. The leg band design may be closed, or opened (seamed) provided that it is tamper evident. This subsection shall not prohibit the use of a unique identifier for parakeets.

(d) A microchip that includes the unique identifier for each individual psittacine bird may be used in place of a leg band. An appropriate microchip reader shall be available at any pet shop licensed pursuant to section 22-344 of the Connecticut General Statutes where a psittacine bird is normally kept.

(e) Any psittacine bird imported into Connecticut shall be accompanied by a health certificate signed by a veterinarian licensed in the state or country of origin certifying that

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such psittacine bird was healthy before shipment and had no known exposure to avian chlamydiosis in the 60 days preceding the date of issuance of the health certificate. The certificate shall include the date of veterinary inspection, and for each psittacine bird the description (i.e. species, common name, variety), and source including name, address, and phone number of the prior owner. The unique identifier as it appears on the leg band as described in subsection (c) of these regulations or the microchip as described in subsection (d) of these regulations shall be present on either the health certificate accompanying the psittacine bird or a document attached to the health certificate. If the unique identifier is located on a document attached to the health certificate, the health certificate shall indicate where on the attached document the unique identifier is located.

(f) The breeder of any parakeet imported, purchased, sold, exchanged, bartered or given away shall be indicated on either:

(1) A metal leg band that has a diameter adequate for the species that may be closed, or opened (seamed) provided that it is tamper evident; or

(2) A microchip provided that an appropriate microchip reader shall be available at any pet store licensed pursuant to section 22-344 of the Connecticut General Statutes where a parakeet is normally kept.

Such breeder shall also be identified on records required pursuant to subsection (b) of this section and the health certificate required pursuant to subsection (e) of this section except that on any document where said subsections require a unique identifier the name of the breeder shall be included in lieu thereof.

(Effective October 25, 1989; Amended January 3, 2011)

Sec. 19a-36-A24. Distribution and use of microbial agents for control of animal life

Microbial agents capable of producing disease in man shall not be sold, distributed or used for the control or destruction of any form of animal life.

(Effective October 25, 1989)

Sec. 19a-36-A25. Laboratories to register

Any person, firm or corporation, or the duly authorized agent thereof, operating or maintaining a laboratory in which there is made any examination, determination or test specified in section 19a-36-A26, shall register such laboratory with the state department of health before any such examination, determination or test is made. The carrying on of any of the examinations, determinations or tests specified in said section shall be deemed the operating or maintaining of a laboratory.

(Effective October 25, 1989)

Sec. 19a-36-A26. Registration required when. Exemptions

(a) Except for laboratory work of the types hereinafter exempted, registration is required for any of the following laboratory procedures:

(1) Those which utilize any living agent capable of causing human infections or

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reportable disease of man, or which are used to secure evidence bearing upon the presence or absence of such living agents or the illnesses caused;

(2) those used to determine the sanitary quality of water or the amount of pollution therein or to control and evaluate the effectiveness of water treatment;

(3) those performed on sewage, sewage effluent or sewage sludge in connection with investigation of sources of pollution, problems of sewage disposal or effectiveness of sewage treatment;

(4) any examination, determination or test performed on any sample of milk, cream, frozen dessert, milk product or milk beverage or of any container or package used or intended to be used for holding any such product;

(5) those used to determine the sanitary quality of any substance used as a food, or as an ingredient of food or as a container for food, or to determine whether or not such substance may be harmful to health;

(6) those performed on any material or substance for the purpose of determining the effectiveness of sanitation in the establishment serving food or beverages to the public;

(7) those performed on air or materials contributing substances to the air which may be prejudicial to health, except those performed for routine operational control or maintenance purposes.

(b) Laboratories performing any of the work specified above shall be exempt from the requirements of this section only when all such work is done under one or more of the following conditions:

(1) When laboratory findings are obtained in a laboratory facility and service maintained by a licensed practitioner of a healing art exclusively for the examination of his own patients within the scope of his license to practice;

(2) when the laboratory has been established as an agency of the state or federal government for the purpose of providing data for state or federal officials in the enforcement of the dairy and pure food and drug laws;

(3) when laboratory work is confined to butter fat tests on milk and cream for use in determining payment to producers of such products under provisions of the general statutes;

(4) repealed, March 23, 1976;

(5) when laboratory findings are obtained on materials derived from animals in a laboratory facility and service maintained by a veterinarian licensed to practice in Connecticut performing laboratory examinations exclusively on animals under his or her care and treatment.

(c) When the laboratory work consists solely of those tests necessary to control the operation of water treatment plants under the supervision of operators whose qualifications have been approved by the state department of health or of sewage treatment plants under the supervision of operators whose qualifications have been approved by the state department of environmental protection, upon recommendation of the division of environmental health services in the former case or the state department of environmental protection in the latter case, the department shall grant registration without approval as

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provided in section 19a-36-A33 solely for the purpose of allowing such operators to perform those tests as shall be required for the control of treatment. Such granting of limited registration or renewal thereof may be made by the department without prior inspection or investigation of facilities, personnel, equipment and proficiency.

(Effective October 25, 1989)

Sec. 19a-36-A27. Application for registration or reregistration

(a) Application for registration shall be made on forms provided for the purpose by the state department of health and shall set forth clearly essential information concerning the laboratory, including its name, its location, the name of the person, firm or corporation owning or operating it, and such additional information as the state department of health may at any time deem necessary regarding the tests to be made, the housing, equipment and personnel of the laboratory. As part of the application for registration, the owner of the laboratory, or his duly authorized agent, shall designate a person to be in charge of the laboratory and shall agree to notify the state department of health in writing before any change in status of the person in charge or removal of the laboratory to new quarters is made.

(b) In a similar manner, application for reregistration of such laboratory shall be made (1) biennially within thirty calendar days prior to expiration of the registration then current, (2) before the laboratory is moved to new quarters, (3) whenever a change in status of the person designated to be in charge is about to be made or (4) whenever registration has lapsed for any cause.

(Effective October 25, 1989)

Sec. 19a-36-A28. Conditional permission to operate laboratory

The state department of health may extend conditional permission to operate an unregistered laboratory for a period not to exceed thirty days pending completion of investigation or carrying out of conditions imposed prior to registration or reregistration.

(Effective October 25, 1989)

Sec. 19a-36-A29. Granting of registration

Registration or reregistration of a laboratory will be granted only after the state department of health has determined by inspection and investigation that no condition or circumstance exists which would, in the opinion of the state department of health, cause the laboratory to be operated in a manner prejudicial to the health of the public.

(Effective October 25, 1989)

Sec. 19a-36-A30. Suspension or revocation of registration

Registration of a laboratory may be suspended at any time when investigation has shown that the registration agreement has been violated or that the laboratory is being operated in a manner which may be prejudicial to the health of the public. Registration may be revoked

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for such cause after notice to and hearing of the parties interested.

(Effective October 25, 1989)

Sec. 19a-36-A31. Inspections and investigation by state department of health

Representatives of the state department of health shall be granted reasonable access to laboratory quarters and records for inspection and investigation. Whenever necessary to evaluate the accuracy of any type of laboratory work done in a laboratory which is registered or has applied for registration, said department will require technical reviews of procedures used or submit a reasonable number of suitable specimens or samples and require reports thereon.

(Effective October 25, 1989)

Sec. 19a-36-A32. Prohibition of transmission of material to unregistered laboratory

No person, firm or corporation shall, without approval in writing from the state department of health, maintain, conduct or operate a station or office for the reception from the public of materials to be transmitted to a laboratory for the making of any clinical, medical, or sanitary laboratory examination, determination or test except when the laboratory in which the work is to be done is currently registered with the state department of health or is exempt from registration requirements, as provided for in section 19a-36-A26.

(Effective October 25, 1989)

Sec. 19a-36-A33. Requirements and standards for approval

(a) The department of Public Health will approve registered laboratories only under the following circumstances:

(1) When such approval is sought in order to comply with provisions of the general statutes or the public health code of Connecticut making approval a prerequisite for the performance of laboratory tests for the purposes specified therein;

(2) When laboratory tests for the diagnosis of reportable diseases of man are to be made in a laboratory serving a hospital, or

(3) Whenever the department of Public Health deems that the application of standards for approval of a laboratory would be in the interests of the public health. When any of the foregoing conditions exist, the person in whose name a laboratory is registered may apply to the department of Public Health for approval of such laboratory to perform one or more examinations, determinations or tests specified in section 19a-36-A26 of the Regulations of Connecticut State Agencies. If after inspection and investigation such laboratory is found to conform to the requirements and standards for approval that are required by said department, the laboratory may be designated as an approved laboratory to perform examinations, determinations or tests specified. In recognition thereof the department shall issue a certificate of approval in the name of the individual who is designated by the owner of the laboratory, or by his authorized agent, to be the individual in charge of the work for

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which approval is requested.

(b) Requirements and standards for approval of laboratories shall be based upon the ability and qualifications, as determined by investigation or examination, of the individual designated by the owner to be in charge of the laboratory and to the extent deemed necessary at any time of persons performing the examinations, determinations or tests; upon the standards and agreements set forth in section 19-4-1 of the Regulations of Connecticut State Agencies; and upon agreement on the part of the individual in charge to adhere to the standards upon which approval is based for making the specified examinations, determinations or tests. Approval shall lapse at any time that registration has expired or approval may be revoked or suspended at the discretion of the department of Public Health if at any time the standards of performance are found to be below that required. Certificates of approval shall expire at the end of each registration period and shall be returned at any time if revoked or suspended.

(c) Environmental laboratories, as defined in section 19a-29a (a) of the Connecticut General Statutes, located outside of the geographical boundaries of Connecticut must be approved to test samples that have originated in the state of Connecticut. For the purposes of this section:

(1) “Matrix” means the component or substrate (e.g. drinking water, wastewater, soil) which contains the analyte of interest.

(2) “Analyte” means the substance being measured in an analytical procedure.

(3) “Primary accrediting authority” means the agency or department designated at the Territory, State or Federal level as the recognized authority with responsibility and accountability for granting approval for determination of a given analyte in a given matrix for an environmental laboratory.

(A) In order to obtain approval, an applicant shall complete an application for registration in accordance with section 19a-36-A27 of the Regulations of Connecticut State Agencies, remit a biennial fee of \$1000.00 as specified in section 19a-29a (c) of the Connecticut General Statutes, and it must be established that:

(i) The laboratory is certified or approved by its primary accrediting authority for the analytes and matrices for which approval is requested, and the certification standards of the primary accrediting authority are equivalent to or exceed Connecticut’s standards, and;

(ii) The requirements of section 19a-36-A62 of the Regulations of Connecticut State Agencies regarding qualifications of the director are complied with.

(B) For analytes and/or matrices for which the primary accrediting authority does not have a Connecticut equivalent certification, the Department of Public Health may approve the laboratory based on its certification or approval in a Territory, Federal, State or other nationally recognized program whose standards are equivalent to, or exceed Connecticut’s standards, such as, but not limited to, the National Environmental Laboratory Accreditation Program.

(C) An approval shall automatically expire:

(i) Upon a change in the ownership of the laboratory, unless 30 days in advance of the

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transfer, a new completed application is received by the department. In such case the Department of Public Health shall grant conditional permission to operate the laboratory for 30 days or until the department either approves or disapproves the new application, whichever is sooner, in accordance with section 19a-36-A28 of the Regulations of Connecticut State Agencies.

(ii) Upon any change in the information in the laboratory application, unless within two weeks of said change, a new appropriately updated application is received by the department. In such case the department shall grant the laboratory conditional permission to operate for 30 days or until the department either approves or disapproves the new application, whichever is sooner, in accordance with section 19a-36-A28 of the Regulations of Connecticut State Agencies.

(iii) Upon a change in the director of the laboratory, unless a new director is hired by the laboratory owner and approved by the department within 30 days after the termination of the previous director.

(D) If the certification of the laboratory, upon which the department bases its approval, is suspended or revoked, the approval of the department is automatically and immediately likewise suspended or revoked. An out of state laboratory must notify the department in writing of any changes in its certification within 14 days of said change.

(E) The owner shall maintain the current address of its laboratory with the department. Any notice with respect to the operation of the laboratory sent to the owner at the laboratory address on file is effective notice. Service of process by the department upon the owner shall be effective when made on the Connecticut Secretary of State's Office.

(Effective October 25, 1989; Amended October 10, 2006)

Sec. 19a-36-A34. Serologists to be certified

Before any serological test for syphilis may be reported for use or used as an aid to the diagnosis or the exclusion of syphilis, any person performing such test shall have demonstrated a standard of proficiency in performing such test which will fulfill the requirements of the state department of health and such person shall hold an unexpired certificate to perform such test which shall be issued by the state department of health subject to revocation for cause and to annual renewal. Serological tests performed entirely for instructional, research or experimental purposes and serological tests performed by a physician for use only in his private practice are exempted from this requirement.

(Effective October 25, 1989)

Sec. 19a-36-A35. Standard tests for syphilis

A standard laboratory blood test or a standard serological test for syphilis as required under the provisions of the general statutes or the public acts shall be a serological test approved by, and performed in a manner that meets the approval of the state department of health. The following types of tests are so approved: VDRL slide flocculation, fluorescent treponemal antibody absorption (FTA-ABS), automated reagin (ART) and rapid plasma

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reagin (RPR) circle card tests.

(Effective October 25, 1989)

Sec. 19a-36-A36. Funeral directors to report deaths of reportable communicable diseases

Within twelve hours after being called to take charge of a human body dead of a communicable disease listed pursuant to section 19a-36-A2, the funeral director shall report the case to the local director of health and the body shall be prepared for burial in accordance with section 19a-36-A39.

(Effective October 25, 1989)

Sec. 19a-36-A37. Funerals of persons dead of reportable communicable diseases

Funerals of persons dead of any communicable disease listed pursuant to section 19a-36-A2 shall be conducted in such a manner that the family and public shall have no opportunity to come into contact with the body.

(Effective October 25, 1989)

Sec. 19a-36-A38. Definitions

The intent and meaning of certain words and phrases as used in sections 19a-36-A39, 19a-36-A40, 19a-36-A41 and 19a-36-A42 are as follows:

(a) **Washed.** A dead human body shall be considered as washed when the entire surface of the body has been bathed with a disinfecting solution.

(b) **Embalmed.** A body shall be considered embalmed when it has had injected into the circulatory system embalming fluid in an amount not less than five per cent of the body weight and when such cavities have been injected as may be necessary to properly preserve the body and render it sanitary.

(c) **Wrapped.** A body shall be considered as wrapped when it has been bandaged with five thicknesses of cloth saturated with a disinfecting solution, provided, when a body has been embalmed, the face, arms and hands need not be so bandaged.

(d) **Embalming fluid.** For the purposes mentioned in section 19a-36-A40, an embalming fluid shall be a fluid containing not less than four per cent formaldehyde gas by weight.

(e) **Disinfecting solution.** A disinfecting solution shall be an aqueous solution containing not less than five per cent of phenol by weight, a 1-500 solution of bichloride of mercury or such other solution as shall be equivalent to five per cent phenol in germicidal action when tested in the presence of organic matter by a method and in a laboratory that has met the approval of the state department of health for that purpose, provided such other solution shall have been approved in writing by the commissioner of health. The active ingredients shall be named on the label of any package or container in which a disinfecting solution is offered for sale.

(Effective October 25, 1989)

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Sec. 19a-36-A39. Preparation for burial of persons dead of reportable communicable diseases

Human bodies dead of any communicable disease listed pursuant to section 19a-36-A2 shall be prepared for burial by being washed with a disinfecting solution or embalmed or wrapped.

(Effective October 25, 1989)

Sec. 19a-36-A40. Transportation of dead bodies

(a) Dead human bodies to be transported by common carrier shall be embalmed or wrapped and then enclosed in a casket, and outside box or, in lieu of such double container, be enclosed in an impervious container acceptable to the commissioner of health.

(b) Dead human bodies to be removed from the place of death to another location for preparation shall be temporarily prepared by enclosing in an impervious container. The licensed embalmer having charge of such a body may sign the certificate required in section 7-62 of the general statutes, but in so doing, such licensed embalmer obligates himself to further prepare the body as required by section 19a-36-A39 as soon as practicable after arrival at his regular place of business.

(c) The impervious containers mentioned in subsections (a) and (b) of this section shall be cleansed and washed with a disinfecting solution after each use.

(Effective October 25, 1989)

Sec. 19a-36-A41. Disinterment permits

Embalmed bodies which have been placed in receiving vaults shall not be regarded the same as disinterred bodies until after the expiration of thirty days. All bodies remaining in a receiving vault over thirty days shall be treated the same as disinterred bodies. The above shall not apply during winter months to embalmed bodies which are to be buried in any cemetery in Connecticut before the first of June following the date in which they are placed in such receiving vault, but permits may be granted for removal and burial the same as if burial were made immediately after death.

(Effective October 25, 1989)

Sec. 19a-36-A42. Care in handling bodies dead of a communicable disease

Any licensed embalmer who has in charge the preparation of a body dead of a communicable disease shall take the necessary precautions to prevent the spread of infection, and such licensed embalmer shall instruct the owner of the building or the family in which the death occurs, or both, that it is unlawful to remove any infectious material, clothing, instrument or thing until thoroughly disinfected by combustion, by boiling for at least ten minutes or by thorough saturation or immersion in a disinfecting solution for at least two hours.

(Effective October 25, 1989)

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Sec. 19a-36-A43. Sanitation of buildings, equipment and instruments

All buildings occupied or used and all equipment and instruments used or owned by funeral directors or licensed embalmers shall be kept in a sanitary condition acceptable to the state department of health.

(Effective October 25, 1989)

Sec. 19a-36-A44. Inspection of buildings, equipment and instruments

The state department of health may, at any time, make an inspection of the buildings occupied or used or the equipment or instruments owned or used by funeral directors or licensed embalmers in the discharge of their business. When such buildings, equipment or instruments are found to be in such an insanitary condition as to be detrimental to the public health, and when it also is found that such buildings, equipment or instruments are owned or used by a licensed embalmer, such fact shall be reported to the state board of examiners of embalmers and funeral directors with the recommendation that the license be not renewed to the licensed embalmer who owns or operates such insanitary place of business.

(Effective October 25, 1989)

Sec. 19a-36-A45. Repealed

Repealed April 20, 1995.

Sec. 19a-36-A46. Sale of turtles

(1) No live turtle shall be sold in Connecticut until examination in the laboratory of the state department of health of three specimens of water from the tank in which the turtle is kept, taken not less than forty-eight hours apart by a representative of either a local health department or state department of health fails to show the presence of salmonella organisms. (2) Should a single such examination show the presence of salmonella organisms all turtles in the tank shall be destroyed. (3) Persons who import, purchase, sell, exchange, barter, give away or otherwise deal in turtles shall keep records of such transactions embodying information required by the state department of health for a minimum period of two years, which records shall be open for inspection by a representative of the local director of health or the state department of health. (4) In any location where turtles are offered for sale the vendor shall post warnings which adequately inform the public that the transmission of salmonella disease by turtles is possible.

(Effective October 25, 1989)

Sec. 19a-36-A47. Plasmapheresis centers and blood collection facilities: Definitions

For the purposes of sections 19a-36-A47 to 19a-36-A55 inclusive, the following definitions shall apply:

(a) “Advisory Committee on Plasmapheresis and Blood Banking” means a group of consultants, appointed by the state commissioner of health and serving in a voluntary capacity, to advise the department of health on matters relating to the regulation of

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plasmapheresis and blood banking. Two of the consultants shall be physicians licensed to practice in Connecticut who are in charge of blood banking facilities in hospitals licensed in accordance with sections 19a-A490 to 19a-A503 of the general statutes; one shall be a physician licensed to practice in Connecticut who is associated with or employed by a plasmapheresis or blood banking center which is not a part of a licensed hospital; one shall be a physician who is licensed to practice in Connecticut, is board-certified in clinical pathology, and is the director of a hospital laboratory registered and approved in accordance with sections 19a-36-A25 to 19a-36-A35 and section 19-4-1 of the public health code; and one shall be a licensed physician who is not associated with a plasmapheresis center or blood banking facility. The commissioner of health, if he deems it necessary, may appoint additional consultants to this advisory committee.

(b) “Department” means the state department of health.

(c) “Director” means the person designated by the registrant to be responsible for the daily technical and scientific operations of the plasmapheresis center or blood banking facility including the choice and application of methods, daily technical and scientific operations, donor selection and care, phlebotomies, and reintroduction of red cells as appropriate.

(d) “Center” means any area where plasmapheresis, plateletpheresis or blood banking operations are conducted.

(e) “Plasmapheresis Center” means any area where blood is removed from a human being to obtain plasma, its components, or the non-erythrocytic formed elements with subsequent reinfusion of the red cells into the donor.

(f) “Blood Collection Facility” means any area where blood is removed from a human being for the purpose of administering said blood or any of its components to any human being.

(g) “Owner” means any individual, firm, partnership, association, corporation, the State of Connecticut, or any municipality or other subdivision thereof, or any other entity whether organized for profit or not.

(h) “Registrant” means the person in whose name the registration is granted. The registrant shall be the owner, if the center is owned by a single individual, or a responsible officer or representative when the center is owned by a group, partnership, firm, corporation, or governmental agency.

(i) “Specimen” means material derived from a human being or body.

(j) “Donor” means any person, whether for profit or not, who submits to plasmapheresis or allows a unit of blood more or less to be taken from his or her body for the purpose of transfusion or preparation of blood derivatives or components.

(k) “Unit” means 450 milliliters of blood more or less.

(l) “Transfusion” means the intravenous administration of whole blood, packed red blood cells, plasma, and other blood components, fractions, or derivatives to a human being.

(Effective October 25, 1989)

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Sec. 19a-36-A48. Registration of a plasmapheresis center and/or blood collection facility

(a) The owner or duly designated registrant shall apply to the department for registration of the center or renewal thereof on forms provided for that purpose by the department. No procedures shall be performed therein until the registrant has been notified by the department that registration is in effect. No such procedures shall be performed after registration has expired or has been suspended or revoked as provided herein until such registration is renewed or reinstated.

(b) In applying for registration, the applicant shall set forth the name and location of the center, a complete statement of its ownership, the name and qualifications of the director, the procedures for which registration is sought and such other information as to quarters, facilities, personnel and proposed operations as the department may require. In the application for registration or renewal thereof, the registrant and director shall agree to abide by all general statutes, regulations and administrative directives pursuant thereto.

(c) Prior to registration, the owner shall cause the quarters, facilities and records of the center to be made available for inspection upon request of a representative of the department and shall cooperate with such representative by furnishing information in any pertinent investigation or inspection. The commissioner or his designee shall inspect each center at least once every twelve months unless the commissioner elects to accept an inspection report from the American Association of Blood Banks in lieu of one annual departmental inspection during any two year period. For the purpose of this subsection, representatives of the department shall have the right of entry into the premises of the center at any time during the hours of operation.

(d) The duration of each registration shall be set at the discretion of the department but no longer than two years from its effective date. The terms of registration or renewal thereof may restrict the scope of operations or establish a time limit for the owner to carry out recommendations based upon inspection or investigation. In all cases, application for renewal of registration shall be made as follows: (1) within thirty calendar days prior to the expiration of the registration then current; (2) before any change in ownership or change in director is made; (3) prior to any major expansion or alteration in quarters in an existing location; and (4) prior to removal of the center to new quarters. Registration or renewal thereof shall not be effective until the registrant is so notified.

(e) A Connecticut registration number will be assigned to the center by the department upon initial registration.

(f) A mobile or temporary blood collection facility shall not require registration provided that the person or organization conducting said facility is otherwise registered in this state in accordance with these regulations.

(g) Additional blood collection facilities shall not require separate registration provided that the person or organization conducting such facilities is otherwise registered in accordance with these regulations and has filed with the department a list of all permanent

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locations.

(Effective October 25, 1989)

Sec. 19a-36-A49. Denial, suspension or revocation of registration

(a) Registration of a center shall be denied, revoked, suspended, limited, or renewal thereof denied for knowingly:

(1) making false statements of material information on an application for registration or renewal thereof or any other documents required by the department;

(2) permitting unauthorized persons to perform any medical or technical procedure such as but not necessarily limited to: plasmapheresis, phlebotomies, and medical history interviews;

(3) demonstrating incompetence in the performance of any procedure;

(4) performing a procedure for which registration has not been granted;

(5) lending the use of the name of the registered center or its personnel to an unregistered center;

(6) operating a program of mobile or permanently fixed collection stations without prior written approval from the department; and

(7) operating the center in a manner which is deemed prejudicial to the public health.

(b) At the discretion of the commissioner of health, the registrant may be directed by written notice to appear not less than ten days after receipt of such notice at a hearing before said commissioner or his agent to show cause why registration should not be denied, suspended, or revoked. When in the judgment of the commissioner of health, conditions so warrant, suspension of the registration may be invoked without prior hearing if the continued operation is prejudicial to the public health. Revocation of a suspended registration will become effective within thirty days after suspension unless otherwise ordered by the commissioner of health. Prior to revocation, the registrant may request a hearing before the commissioner of health or his agent to petition for reconsideration stating upon what grounds such petition is based.

(Effective October 25, 1989)

Sec. 19a-36-A50. Qualifications of director

No person shall be the director of a center unless said person is a physician licensed to practice in Connecticut who is board-certified in clinical pathology or blood banking by the American Board of Pathology, or has received a minimum of one year of specialized training in blood banking, or has equivalent experience and training acceptable to the department.

(Effective October 25, 1989)

Sec. 19a-36-A51. Responsibilities of registrant and director

(a) The registrant shall be responsible to ensure that the center is at all times under the direction of a director acceptable to the department as set forth in section 19a-36-A50.

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Whenever the designated director is to be on leave from his duties for more than thirty calendar days, the registrant shall so notify the department in advance in writing and shall designate, subject to departmental approval, an interim director of the center. The registrant shall notify the department in advance whenever the designated director is about to sever connection with the center.

(b) The registrant and director shall, if different persons, be jointly and severally responsible for the operation of the center in compliance with sections 19a-36-A47 to 19a-36-A55 inclusive, and with any other pertinent regulatory and statutory requirements.

(c) The director shall be responsible for the proper performance of all procedures including phlebotomies, plasmapheresis and all procedures performed by subordinates. He shall be responsible for the continuous application of quality control procedures to the work in accordance with recommendations and directives of the department.

(d) Except for illness, vacation, or other justifiable leave, the director shall be present and in active direction of the center during at least one-half of its normal working hours each week. When the total normal working hours of a center exceed thirty hours weekly, a total of fifteen working hours shall satisfy the requirements of this subsection.

(Effective October 25, 1989)

Sec. 19a-36-A52. Minimum standards for operation of centers

(a) The center shall be operated in compliance with all applicable laws, ordinances, and regulations and with all administrative directives pursuant thereto that shall be issued by the department.

(b) Quarters in which any procedures are performed or specimens collected shall be kept free from filth, excessive dirt or other objectionable conditions, shall be adequately lighted and ventilated, shall be of adequate size and arrangement for the proper conduct of the work and shall be free from unnecessary safety hazards.

(c) Equipment shall be adequate and in good order at all times as considered necessary for the proper handling of procedures for which registration may be granted.

(d) All persons engaged in the performance of any procedures in the center shall be qualified to do the work in the opinion of the director subject to appraisal by the state department of health.

(e) No misrepresentation of the scope of the procedures performed by the center, or of the qualifications or special abilities of persons associated with the center, shall be permitted.

(f) No person shall be subjected to plasmapheresis except when a physician licensed to practice in Connecticut is on the premises.

(Effective October 25, 1989)

Sec. 19a-36-A53. Standards for plasmapheresis and blood collection

The department shall, upon recommendation of the Advisory Committee, establish such standards as it deems necessary for the performance of plasmapheresis and phlebotomies. Such standards shall include but may not be limited to: donor selection requirements, blood

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container and pilot tube identification, donor arm preparation, phlebotomy, collection of blood, plasmapheresis, availability of equipment in the event of donor reaction, processing requirements for donor blood, space and ventilation requirements, and equipment maintenance.

(Effective October 25, 1989)

Sec. 19a-36-A54. Maintenance of records and reports

(a) The medical history and a written record of weight, blood pressure, hemoglobin level (or acceptable alternate test), temperature, pulse, and such other tests as shall be required shall be maintained for a minimum of one year.

(b) Prior to plasmapheresis, each center shall require positive identification of the donor.

(Effective October 25, 1989)

Sec. 19a-36-A55. Laboratory tests

Such laboratory tests as deemed necessary in any standards as may be established pursuant to section 19a-36-A53 shall be performed in a laboratory approved in accordance with section 19a-36-A33.

(Effective October 25, 1989)

Sec. 19a-36-A56. Repealed

Repealed October 10, 2008.

Environmental Laboratories

Sec. 19a-36-A57. Definitions

As used in sections 19a-36-A57 through 19a-36-A63:

(1) “Advisory committee” means a group of consultants, appointed by the commissioner and serving in a voluntary capacity, to advise the commissioner on matters relating to the regulation of environmental laboratories.

(2) “Commissioner” means the Commissioner of Public Health.

(3) “Department” means the Connecticut Department of Public Health.

(4) “Environmental laboratory” means any facility or other area defined in subsection (a) of Section 19a-29a of the Connecticut General Statutes.

(Adopted effective November 29, 1995)

Sec. 19a-36-A58. Identification and tracking of samples

Every sample received in an environmental laboratory for testing shall be numbered or otherwise marked so that it may be identified and related to the source from which it was derived. A dated record of its receipt, disposition and examination and of the findings obtained shall be made and kept on file for a minimum of two (2) years after receipt.

(Adopted effective November 29, 1995)

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Sec. 19a-36-A59. Examination of samples

An environmental laboratory shall have available at all times in the immediate bench area of personnel engaged in examining samples and performing related procedures within a speciality (e.g., minerals, nutrients, volatile organics, trace metals) current laboratory manuals or other complete written descriptions and instructions related to the analytical methods used by those personnel, designated and dated to reflect the most recent supervisory review. Such manuals shall also contain information concerning preparation and storage or reagents, standards and calibration procedures, and pertinent literature references.

(Adopted effective November 29, 1995)

Sec. 19a-36-A60. Referral of samples

(a) An environmental laboratory shall refer samples for testing only to an environmental laboratory that is registered or approved by the department.

(b) An environmental laboratory shall perform at least seventy (70) percent of those tests for which it has approval and refer out those tests for which approval has not been granted.

(c) When samples have been referred, reports shall be done by one of the following:

(1) The testing environmental laboratory, with permission from the referring environmental laboratory, may send test results directly to the person who ordered the tests.

(2) The referring environmental laboratory shall indicate on the report to the person who ordered the test the name and address of each environmental laboratory at which a test was performed.

(Adopted effective November 29, 1995)

Sec. 19a-36-A61. Proficiency testing

(a) An environmental laboratory shall enroll in a proficiency testing program approved by the department.

(b) An environmental laboratory shall successfully participate in an approved program for each analyte or test for which it has approval.

(c) The proficiency testing samples shall be examined or tested with the environmental laboratory's regular workload by personnel who routinely perform the testing in the environmental laboratory, using methods approved by the department.

(Adopted effective November 29, 1995)

Sec. 19a-36-A62. Qualifications of director

No person shall be a director of an environmental laboratory unless one (1) of the following qualifications are met.

(a) When microbiology is performed, the director shall have at least:

(1) a baccalaureate degree from an accredited institution including a minimum of eight (8) semester hours of microbiology; and

(2) a minimum of one (1) year of pertinent experience in environmental microbiology.

(b) When chemical analyses are performed, the director shall have at least:

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(1) a baccalaureate degree from an accredited institution including a minimum of eight (8) semester hours of inorganic and/or organic chemistry; and

(2) a minimum of one (1) year of pertinent experience in environmental chemistry.

(Adopted effective November 29, 1995)

Sec. 19a-36-A63. Advisory committee

The advisory committee shall consist of:

(a) two (2) private environmental laboratory directors;

(b) two (2) public environment laboratory directors;

(c) two (2) members from public water utilities;

(d) one (1) specialist in microbiology from a registered or approved environmental laboratory;

(e) one (1) specialist in inorganic chemistry from a registered or approved environmental laboratory;

(f) one (1) specialist in organic chemistry from a registered or approved environmental laboratory;

(g) one (1) person who is not a laboratory director and has no financial interest in any laboratory registered with the department; and

(h) one (1) person who is the owner of an environmental laboratory.

(Adopted effective November 29, 1995)

Public Swimming Areas

Sec. 19a-36-B61. Public swimming areas

(a) **Definitions.** As used in this section:

(1) “Public swimming area” means a designated location, together with any buildings, toilet facilities, the water and the land area used in connection therewith, at any natural or artificial pond, lake, stream, tidal water or other body of fresh or salt water that is advertised as a place for swimming and is accessible to the public. Public swimming area does not include: (A) swimming areas in connection with or appurtenant to single family dwellings and used solely by persons residing in such dwellings and such person’s guests, including but not limited to those swimming areas accessible only as part of a lake association, beach association or condominium; (B) any state owned or operated swimming areas; and, (C) public swimming pools that are regulated under Section 19-13-B33b of the Regulations of Connecticut State Agencies.

(2) “Department” means the Department of Public Health.

(3) “Director of Health” means the director of a local health department or district health department approved by the commissioner as specified in sections 19a-200 and 19a-242 of the Connecticut General Statutes.

(4) “Notification system” means a public information system used to notify the public regarding lifeguard status and the opening or closing of a public swimming area, including

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but not limited to, signs or flags.

(b) **General requirements.** No city, town, borough, institution, person, firm, corporation or other entity shall designate or construct a public swimming area until the director of health for the municipality in which the public swimming area is located has approved the location of such public swimming area. A city, town, borough, institution, person, firm, corporation or other entity operating or maintaining a public swimming area shall comply with the following requirements:

(1) Every public swimming area shall be provided with on-site toilet facilities unless the director of health determines that adequate toilet facilities are already provided elsewhere. Separate toilets for men and women shall be provided, with at least one toilet for every two hundred women and at least one toilet for every three hundred men, and at least one handwashing sink or hand sanitation station shall be provided with each required toilet. All toilet facilities and restroom accommodations shall be constructed and located so that no contamination of the waters used by the swimmers will occur. Toilets shall be installed with the approval of the director of health so as not to create any health or safety issues. Toilets shall be kept in good repair and maintained at all times in a sanitary condition. The location of all toilet facilities shall be plainly indicated by signs.

(2) The dressing rooms, hallways, toilet rooms, shower rooms or other rooms to which swimmers have access shall be kept clean, well ventilated, and in good repair. The floors shall also be treated daily with a 0.5% chlorine solution, or other equivalent disinfectant.

(3) The area open for authorized swimming shall be clearly designated.

(4) Swimming in public swimming areas shall be restricted to designated areas and during assigned hours of operation.

(5) Diving shall be permitted only off a diving board. No diving boards greater than sixteen feet in length shall be permitted. The owner of the property shall ensure that the diving area is in compliance with the required water depths at all times.

(A) For diving boards of a height of no greater than one meter above the water surface, the diving area shall meet the following requirements:

- (i) Not have any submerged or overhead obstructions;
- (ii) Have a minimum water depth at all times of eleven feet for at least sixteen feet linear beyond the plummet of the diving board; and
- (iii) Have a minimum water depth at all times of eleven feet for at least eight feet horizontal on each side of the plummet of the diving board.

(B) For diving boards of a height greater than one meter above the water surface, the diving area shall meet the following requirements:

- (i) Not have any submerged or overhead obstructions;
- (ii) Have a minimum water depth at all times of twelve feet for at least sixteen feet linear beyond the plummet of the diving board; and
- (iii) Have a minimum water depth at all times of twelve feet for at least eight feet horizontal on each side of the plummet of the diving board.

(C) When no diving board is present, a sign stating the following shall be conspicuously

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posted: “No diving is permitted”.

(6) Lifeguard services.

(A) When no lifeguard service is provided, one or more warning signs shall be posted in one or more visible locations. The warning sign shall state “Warning – No Lifeguard on Duty” with letters that are legible and at least four inches high.

(B) During the period when the swimming area is open for use, when lifeguard service is provided, the owner of the property shall provide the following:

(i) A notification system to alert swimmers as to where and when lifeguard services are available;

(ii) Appropriate lifesaving equipment, including, but not limited to, a rescue tube, to each lifeguard on duty that the lifeguard has been trained to use;

(iii) A telephone or equivalent emergency communication device for emergency use when the area is staffed by a lifeguard; and

(iv) A raised stand at least four feet in height for the lifeguard, placed such that all areas of the public swimming area are visible from the stand to the one or more lifeguards on duty. The director of health may approve an appropriate alternative to the four foot high raised stand if the director of health determines that all points of the public swimming area can still be visible to the lifeguard on duty.

(7) All public swimming areas shall have a sign posted in one or more visible locations, with signage not less than a half-inch type in size, containing the following information:

(A) Hours of lifeguard coverage if applicable;

(B) Emergency phone information indicating whether a phone is available; and

(C) Location of the nearest first aid unit if one is provided on the premises.

(8) Whenever a public swimming area is closed or reopened pursuant to the provisions of this subsection, the director of health shall comply with the following requirements:

(A) Closure: immediately have put in place a notification system, in one or more conspicuous locations, including the immediate swimming area, notifying swimmers of the sections of the public swimming area that are closed.

(B) Reopening: have removed all closure notifications.

(9) The following shall be prohibited in all public swimming areas: (A) boats, unless used for rescue purposes; (B) washing of persons and articles; (C) littering; and (D) glass containers.

(10) Domestic animals shall be prohibited in the water and on the immediate shoreline associated with the water of a public swimming area when the public swimming area is open for use.

(11) The director of health may:

(A) Inspect all public swimming areas to determine compliance with the provisions of this section.

(B) Issue an order which may result in a closure of the public swimming area, in part or in whole, to the owner of the public swimming area, when the director of health determines: The public swimming area shall remain closed until such time as the director of health

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determines that the cause for closure has been corrected.

- (i) There is a violation of the provisions of this section; or
 - (ii) The public swimming area is not being maintained in acceptable sanitary conditions;
- or
- (iii) A condition is found that constitutes a public health hazard, safety hazard or a health nuisance to the swimmers; or
 - (iv) There is evidence of communicable disease being transmitted in order to end the transmission of the disease.

The public swimming area shall remain closed until such time as the director of health determines that the cause for closure has been corrected.

(Effective March 17, 2014)

Clinical Laboratories

Sec. 19a-36-D1—19a-36-D19. Reserved

Sec. 19a-36-D20. Definitions

As used in sections 19a-36-D20 through 19a-36-D39:

(1) “Advisory committee” means a group of consultants, appointed by the commissioner and serving in a voluntary capacity, to advise the department on matters relating to the regulation of clinical laboratories. The advisory committee shall consist of two hospital laboratory directors who are certified by the American Board of Pathology in both clinical and anatomic pathology; two private clinical laboratory directors; and four laboratory specialists specializing in the fields of cytopathology, clinical chemistry, hematology, and microbiology of which two shall represent laboratories in hospitals licensed in accordance with chapter 368v of the general statutes and two shall represent private clinical laboratories; and a physician who is not a pathologist and who has no financial interests in any laboratory licensed and/or registered with this department.

(2) “CLIA” means the Federal Clinical Laboratory Improvement Amendments of 1988, Title 42 Part 493 of the code of federal regulations.

(3) “Commissioner” means the commissioner of public health.

(4) “Department” means the department of public health.

(5) “Director” means the person designated by the licensee to be responsible for the daily technical and scientific operations of the laboratory, including choice and application of methods, supervision of personnel and reporting of findings.

(6) “Examination” means an investigation, all or any part of which is necessary to obtain an accurate result, which includes the process of instructing the patient, preparing the specimen collection site, choosing the appropriate collection technique, obtaining a valid specimen, assuring the patient’s well being, the judicious handling, transporting and processing of the specimen, and reporting the results in a clear and concise manner to the practitioner whose order initiated the process.

(7) “High complexity tests” means laboratory tests categorized as high complexity in

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accordance with CLIA.

(8) “Laboratory” means any clinical laboratory as defined in Section 19a-30 of the Connecticut General Statutes or other area, except those specifically exempted by the Connecticut General Statutes, where any type of specimen or material derived from a human being or body is examined to obtain findings bearing upon the presence, absence, prognosis or treatment of disease or upon susceptibility thereto.

(9) “Licensee” means the person or persons in whose name licensure of a laboratory has been sought and granted; this shall be the owner if an individual, the owners if a partnership of two, or a responsible officer of any other group, firm or corporation owning the laboratory.

(10) “Moderate complexity tests” means laboratory tests categorized as moderate complexity in accordance with CLIA.

(11) “Non-waived laboratory tests” means moderate and high complexity tests which are not included in the waived tests as set forth in Title 42 Part 493 of the code of federal regulations.

(12) “Owner” means any individual, partnership, group, firm or corporation holding or claiming ownership of or title to a laboratory.

(13) “Specimen” refers only to materials derived from a human being or body.

(Adopted effective June 4, 1996)

Sec. 19a-36-D21. Licensure required

The owner shall apply to the department for licensure of the laboratory or renewal thereof on forms provided for that purpose. No clinical laboratory tests or examinations shall be performed therein until the licensee has been notified by the department that licensure is in effect. No such tests or examinations shall be made after licensure has been suspended or revoked as provided in section 19a-36-D26 of the regulations of Connecticut State Agencies or after the licensee has voluntarily surrendered its license, until such licensure is renewed or reinstated.

(Adopted effective June 4, 1996)

Sec. 19a-36-D22. Application for licensure

(a) In applying for licensure, the applicant shall set forth the name and location of the laboratory, a complete statement of its ownership including the names and addresses of all owners and the agent for service of process and the agent’s address, the name of the director, a list of laboratory tests and examinations for which licensure is sought and such other information as to ownership, quarters, facilities, personnel and proposed operations as the department may require. Application for renewal of licensure shall delineate changes made in the preceding licensure period. When applying for renewal of licensure under this section, the applicant shall simultaneously apply for renewal of any additional registration required by sections 19a-36-A25 through 19a-36-A33 of the regulations of Connecticut State Agencies, and such renewal, when granted, shall be considered to be in force for the issuance

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of such certificates of approval as are required by section 19a-36-A33 of the regulations of Connecticut State Agencies. The applicant shall, as part of each application, agree to abide by such standards of operation as are made a part thereof.

(b) The following clinical laboratories are exempt from licensure:

- (1) laboratories owned and operated by the United States or any agency of the federal government;
- (2) laboratories that perform tests or examinations for research purposes only;
- (3) laboratories that perform tests or examinations for forensic purposes only; and
- (4) laboratories that perform tests or examinations that are exempt for CLIA purposes.

(Adopted effective June 4, 1996)

Sec. 19a-36-D23. Inspection and investigation

The owner shall cause the quarters, facilities and records of the laboratory to be made immediately available for inspection upon request of a representative of the department and shall cooperate with such representative by furnishing information in any pertinent investigation. Failure to allow the Department to inspect constitutes cause for revocation of the laboratory's license.

(Adopted effective June 4, 1996)

Sec. 19a-36-D24. Terms of licensure

The duration of each license shall be set at the discretion of the department, for a period of not less than twenty-four (24) nor more than twenty-seven (27) months from its effective date. The terms of licensure or renewal thereof may restrict the scope of laboratory operations or establish a time limit for the owner to carry out recommendations based upon inspection and investigation. Initial licensure shall not be in force until notice of its effective date and term has been sent to the applicant. Application for renewal of licensure shall be made as follows:

- (a) biennially within thirty calendar days prior to expiration of the license then current;
- (b) thirty (30) days before any change in ownership that will result in an actual change of the licensee of the laboratory or a planned change of director is made; or
- (c) thirty (30) days prior to any major expansion or alteration in quarters, which includes expanding the quarters through construction or relocating the laboratory testing area to another floor, building or location.

(Adopted effective June 4, 1996)

Sec. 19a-36-D25. Denial of licensure

Whenever inspection and investigation pursuant to an application for licensure yield evidence leading to a reasonable presumption that requirements of sections 19a-36-D20 through 19a-36-D38 of the Regulations of Connecticut State Agencies, or of any applicable statute would not or could not be fulfilled, licensure shall be denied.

(Adopted effective June 4, 1996)

Sec. 19a-36-D26. Suspension or revocation of licensure

(a) Licensure may be suspended or revoked whenever in the judgment of the commissioner any one of the following conditions exists:

(1) the laboratory has operated in violation of any applicable statute or regulation or has failed to implement a plan of correction as submitted to the department;

(2) the findings of the laboratory are found, after investigation, to be inaccurate or unreliable beyond the limits of error inherent in the method and such condition is not corrected forthwith;

(3) findings have been reported on specimens that were not tested or examined;

(4) the owner has failed to comply with instructions from the commissioner for the correction of conditions adversely affecting the quality of work;

(5) CLIA certification has been suspended or revoked; or

(6) any other condition of the laboratory that is deemed prejudicial to the public health.

(b) At the discretion of the commissioner, the licensee may be directed by written notice to appear not less than five days thereafter at a hearing before the commissioner or the commissioner's designee to show cause why licensure should not be suspended or revoked. When, in the judgment of the commissioner, conditions so warrant, suspension of licensure may be invoked without prior hearing. Revocation of a suspended license shall become effective within thirty days after suspension unless otherwise ordered by the commissioner. Prior to revocation, the owner may request a hearing, stating upon what grounds such petition is based.

(Adopted effective June 4, 1996)

Sec. 19a-36-D27. Connecticut license number

A Connecticut license number, which will be assigned to the laboratory by the department upon initial licensure, shall be inscribed on all reports, lists of tests, fee schedules and advertisements of the laboratory.

(Adopted effective June 4, 1996)

Sec. 19a-36-D28. List of tests and fee schedules

A copy of each list of tests and each fee schedule issued by a laboratory shall be maintained on file at the laboratory and be available to the department upon its request.

(Adopted effective June 4, 1996)

Sec. 19a-36-D29. Acceptance and collection of specimens

(a) No specimen shall be accepted for analysis or collected by an owner or an employee of the laboratory except when requested by a licensed physician or other licensed person authorized by law to make diagnoses.

(b) No person shall be given any parenteral injection for the collection of a specimen except by a licensed physician or other person so authorized by the Connecticut General Statutes.

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(c) This section shall not prohibit the transmission of specimens collected as specified in subsection (a) to another licensed laboratory or to a qualified laboratory exempt from licensure requirements nor shall it prohibit the acceptance of specimens submitted by a representative of the department for evaluation of testing procedures.

(d) Except for specimens collected by a practitioner of the healing arts or an employee working under such practitioner's direction or by an employee of a hospital or other health care facility licensed in accordance with chapter 368v of the Connecticut General Statutes, no specimen requiring venipuncture shall be accepted for analysis unless taken by an employee of a laboratory licensed in accordance with sections 19a-36-D20 through 19a-36-D38 of the regulations of Connecticut State Agencies. Any blood collection facility other than the actual laboratory facility that is used for the collection of specimens by venipuncture shall be inspected prior to use and a written certificate of approval shall be issued by the department. The licensee or director of a laboratory shall notify the department in writing immediately when the operations of an approved blood collection facility are about to terminate.

(e) An approved blood collection facility shall meet all the requirements set forth in subsection (b) of section 19a-36-D38 and shall possess as a minimum, a blood drawing chair or cot acceptable to the department, a telephone, adequate hand washing and toilet facilities for employees and patients located on the same floor as the blood drawing facility and a written procedure manual detailing the steps to be followed in the event of any emergency. Approved blood collection facilities shall be identified by signs and advertising in a manner which will not suggest that the facility is a laboratory. No laboratory examinations shall be performed in a blood collection facility other than the separation of plasma and serum and the preparative procedures necessary for the blood collection.

(f) The director of the laboratory of which the approved blood collection facility is a part shall be responsible for all aspects of the blood collection facility, including without limitation, physical plant, personnel and processing and transporting specimens. The director or supervisor of the laboratory of which the approved blood collection facility is a part shall be available to blood collection facility personnel at all times during operation of the facility for personal or telephone consultation and shall make on-site monthly inspections of the facility to ensure suitable handling of patients and specimens and to instruct the employees in such matters and in the most recent improvements. The director of the laboratory of which the approved blood collection facility is a part shall establish a protocol for action in cases of emergency which shall include, without limitation, the immediate availability of a physician or emergency medical service. Any technical employee of a blood collection facility shall be proficient in venipuncture, specimen processing as limited by sections 19a-36-D20 through 19a-36-D38 of the regulations of Connecticut State Agencies, and emergency procedures required to aid a distressed patient. Each licensed laboratory shall be limited to six (6) blood collection facilities.

(g) Out-of-state laboratories obtaining specimens in blood collection facilities located in Connecticut shall meet all applicable requirements in this section. In accordance with

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Sections 19a-36-A25 through 19a-36-A33 of the regulations of Connecticut State Agencies, blood collection facilities shall receive written approval from the department before any specimens are collected. Said approval may be revoked by the department at any time in accordance with Section 19a-36-D26 of the regulations of Connecticut State Agencies.

(Adopted effective June 4, 1996)

Sec. 19a-36-D30. Identification of specimens

Every specimen received for testing shall be numbered or otherwise marked so that it may be identified definitely and related to the submitting physician and the patient from whom it was derived. An appropriate, dated record of its receipt, disposition and examination and of the findings obtained shall be made and kept on file for a minimum of one (1) year after receipt or in accordance with the CLIA regulations, Title 42 part 493 of the code of federal regulations, whichever is more stringent.

(Adopted effective June 4, 1996)

Sec. 19a-36-D31. Examination of specimens

(a) No specimen shall be examined if unsuitable for testing because of improper collection, improper preservation, apparent spoilage, excessive time lapse between collection and examination when applicable, or other reasons sufficient to render the findings of doubtful validity.

(b) No specimen of excised tissue shall be subjected to pathological examination except by a physician who is licensed to practice medicine in the state in which the laboratory is located and is certified in anatomic pathology by the American Board of Pathology or the American Osteopathic Board of Pathology or meets all of the education, training or experience requirements to take the examination but has not actually taken and successfully completed the examination. Physicians qualified under these requirements may delegate the responsibility for examination and interpretation of histopathology specimens to an individual who is a resident in a training program leading to certification in anatomic pathology.

(c) No specimen of exfoliated tissue or cells shall be examined except under the supervision and review of a physician who is licensed to practice medicine in the state in which the laboratory is located and meets the personnel qualification standards specified in the CLIA regulations, Title 42 part 493 of the code of federal regulations, as applicable. The Commissioner or the Commissioner's designee may deem a Connecticut licensed physician who is not certified in anatomic pathology to be qualified if said physician possesses qualifications that are equivalent to those required for such certification.

(d) There shall be available at all times, in the immediate bench area of personnel engaged in examining specimens and performing related procedures within a specialty (e.g., clinical chemistry, hematology, bacteriology) current laboratory manuals or other complete written descriptions and instructions relating to the analytical methods used by those personnel, properly designated and dated to reflect the most recent supervisory reviews.

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Such manuals shall also contain information concerning preparation and storage of reagents, control and calibration procedures, and pertinent literature references. Textbooks may be used as supplements to such written descriptions but may not be used in lieu thereof. Technical procedures employed in the laboratory for the processing and examination of specimens shall be performed according to directions detailed in the laboratory manual. Each laboratory shall verify or establish performance specifications for any new test method being utilized including accuracy, precision, reportable range or any other performance characteristic requirements for test performance. If the department deems it necessary, it shall review the laboratory's verification or performance specifications on new methodology to ensure its accuracy, precision, reportable range or other performance characteristic requirements for test performance.

(Adopted effective June 4, 1996)

Sec. 19a-36-D32. Reports of findings

(a) Laboratory findings on a specimen shall be reported directly to the licensed provider who ordered the testing pursuant to authority granted to such provider by chapter 370, 372, 373, 375, 377, 378, 379, 380 or 400j of the Connecticut General Statutes, and may be provided by laboratories other than the department's laboratory to lay persons upon the written request of the provider who ordered the testing. Laboratories other than the department's laboratory may also provide findings upon the written request of providers who did not order the testing, so long as the requesting provider is also statutorily authorized to order such testing pursuant to chapter 370, 372, 373, 375, 377, 378, 379, 380 or 400j of the Connecticut General Statutes, and is providing care to the patient who is the subject of the testing. Nothing in this section shall prohibit the issuance of reports of laboratory findings to town, city or state health officials as required by the Regulations of Connecticut State Agencies or the inspection or impounding of records of such reports by a representative of the department.

(b) No report shall be worded to convey or simulate a diagnosis or prognosis or to specify or suggest specific medication, surgical manipulation or other form of treatment unless signed by a physician licensed to practice in Connecticut or in the state in which the laboratory performing the examinations is located. This subsection shall not prohibit the laboratory from furnishing the normal ranges for the methods of analysis employed in such laboratory nor shall it prohibit the laboratory from identifying patient values that are outside the normal ranges for the methods of analysis employed. When the specimen has been referred for examination to an out-of-state laboratory, the report shall bear or be accompanied by a clear statement that such findings were obtained in such laboratory and shall specify its name and location.

(Adopted effective June 4, 1996; Amended October 3, 2005)

Sec. 19a-36-D33. Qualifications of director

No person shall be the director of a clinical laboratory unless he meets the educational,

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training and/or experiential requirements identified in this section.

(a) For laboratories performing tests categorized as high complexity, the director shall:

(1) be a physician licensed to practice medicine in Connecticut who is certified in anatomic and/or clinical pathology by the American Board of Pathology or the American Osteopathic Board of Pathology or meets all of the education, training or experience requirements to take the examination but has not actually taken and successfully completed the examination; or

(2) hold an earned doctoral degree in a chemical, physical, biological or clinical laboratory science from an accredited institution and:

(A) be certified by the American Board of Medical Microbiology, the American Board of Clinical Chemistry, the American Board of Bioanalysis, the American Board of Medical Laboratory Immunology or other board deemed comparable by the Commissioner; or

(B) have at least two (2) years of laboratory training or experience, or both, and at least two (2) years of experience directing or supervising high complexity testing; or

(3) have a combination of education, training and experience in the clinical laboratory specialty, which, in the judgment of the commissioner, qualifies the individual to direct a laboratory whose services are limited to that specialty.

(b) For laboratories performing tests categorized as moderate complexity, the director shall:

(1) meet the qualification standards identified in subsection (a) of this section; or

(2) hold an earned doctoral degree in medicine or dentistry or in chemical, physical or biological sciences from an accredited institution and have at least one (1) year of experience directing or supervising non-waived laboratory testing; or

(3) have earned a master's degree in a chemical, physical, biological or clinical laboratory science or medical technology from an accredited institution and have at least one (1) year of laboratory training or experience, or both, in non-waived testing and at least one (1) year of supervisory laboratory experience in non-waived testing; or

(4) have earned a bachelor's degree in a chemical, physical or biological science or medical technology from an accredited institution and have at least two (2) years of laboratory training or experience, or both, in non-waived testing and at least two (2) years of supervisory laboratory experience in non-waived testing.

(Adopted effective June 4, 1996)

Sec. 19a-36-D34. Qualifications of other personnel

Clinical laboratory personnel other than the director shall meet the educational, training and/or experiential requirements identified in this section.

(a) For laboratories performing tests categorized as moderate complexity, personnel shall meet the following requirements.

(1) A technical consultant shall:

(A) be a physician licensed to practice medicine in Connecticut who is certified in anatomic and/or clinical pathology by the Board of Pathology or the American Osteopathic

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Board of Pathology or meets all of the education, training or experience requirements to take the examination but has not actually taken and successfully completed the examination; or

(B) hold an earned doctoral or master's degree in a chemical, physical, biological or clinical laboratory science or medical technology from an accredited institution and have at least one (1) year of laboratory training or experience, or both in non-waived testing, in the designated specialty areas of service for which the technical consultant is responsible; or

(C) have earned a bachelor's degree in chemical, physical or biological science or medical technology from an accredited institution and have at least two (2) years of laboratory training or experience, or both in the designated specialty or sub-specialty areas of services for which the technical consultant is responsible.

(2) A clinical consultant shall be qualified to consult with and render opinions to the laboratory's clients concerning diagnosis, treatment and management of patient care and shall:

(A) be qualified as a laboratory director in accordance with Section 19a-36-D33(a) (1) or (2) (A); or

(B) be a physician licensed to practice medicine, osteopathy or podiatry in Connecticut.

(3) Testing personnel shall:

(A) be a physician licensed to practice medicine or osteopathy in Connecticut or have earned a doctoral, master's or bachelor's degree in a chemical, physical, biological or clinical laboratory science or medical technology from an accredited institution; or

(B) have earned an associate degree in chemical, physical or biological science or medical laboratory technology from an accredited institution; or

(C) have earned a high school diploma or equivalent and have documentation of training appropriate for the testing performed prior to analyzing patient specimens.

(b) For laboratories performing tests categorized as high complexity, personnel shall meet the requirements identified in subsection (a) of this section or the requirements identified in CLIA, Title 42, Part 493 of the code of federal regulations, whichever are more stringent.

(Adopted effective June 4, 1996)

Sec. 19a-36-D35. Responsibilities of licensee and director

(a) The licensee shall ensure that the laboratory is at all times under the direction of a director who meets the qualification standards identified in Section 19a-13-D33 of the regulations of Connecticut State Agencies. Whenever the designated director is to be on leave for more than thirty (30) calendar days, the licensee shall so notify the department in advance and shall designate an interim supervisor of the laboratory who meets the qualifications identified in subsection (c) of this section. The licensee shall notify the department at least thirty (30) days in advance of any proposed change of ownership or major expansion or alteration in quarters. At such time that the director severs connection

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with the laboratory, the department may grant permission for the continued operation of the laboratory under an interim supervisor for not more than six (6) weeks. In extenuating circumstances, permission to operate longer without a permanent director may be granted subject to conditions specified in writing by the department.

(b) The licensee and director, if different persons, shall be jointly and severally responsible for the operation of the laboratory in compliance with sections 19a-36-D20 through 19a-36-D38 of the regulations of Connecticut State Agencies, and with other pertinent regulatory and statutory requirements. They shall advise the department within seven (7) days of changes in operations or personnel. They shall submit to the department an annual report on forms provided for the purpose which shall relate to the numbers and types of laboratory examinations performed during the preceding year.

(c) The director shall be responsible for the work of subordinates, the proper management of patient test specimens and records, the proper performance of all tests in the laboratory, and the continual application of quality control procedures to the work in accordance with recommendations and directives of the department. In the absence of the director for any cause, the interim supervisor shall assume the director's responsibilities. Such interim supervisor shall meet the qualification requirements identified in Section 19a-36-D34 of the regulations of Connecticut State Agencies.

(d) Except for illness, vacation or other justifiable leave, the director shall be responsible for the overall operation of the laboratory. No person shall act as director of more than five (5) laboratories.

(Adopted effective June 4, 1996)

Sec. 19a-36-D36. Unethical practices prohibited

(a) **Definitions.** As used in this section:

(1) "Bribe" means any valuable consideration given or promised by a laboratory providing service with a view to influence the behavior of a requester of laboratory services.

(2) "Fee-splitting inducement" means offering or implying a division of payment in any manner between a requester of laboratory services and the laboratory providing the service.

(3) "Fraudulent practice" means one that involves deceit, trickery or cheating.

(4) "Requester of laboratory services" means any person, firm, corporation or other entity that submits specimens, refers specimens for laboratory services or requests or prescribes laboratory tests.

(b) **Permitted practices**

(1) Discounts that represent a reduction in rates due to an actual saving to the laboratory resulting from volume, cost or functional differences may be allowed by the laboratory. If such discount is allowed, it must be available equally to all users of the laboratory's services. A statement of discount policy, if any, shall be clearly indicated on any and all price lists provided to any user of the laboratory's services. A copy of all price lists and fiscal, operating and other business records shall be submitted to the department upon request and at the time of the biennial renewal licensing application.

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(2) Competitive bids for laboratory services are exempt from the provisions of subsection (b) (1) of this section. Any agreement resulting from such bidding must be in the best interest of the patient or consumer.

(c) **Prohibited practices:** Bribes and fee-splitting inducements are prohibited

(1) The following practices are prohibited as bribes: offering or providing to a requester of laboratory services office equipment or services of any kind, including, but not necessarily limited to receptionists, nurses or any other employees, except as provided in subdivision (2) of this subsection. Also prohibited are cars, trips, credit cards, or similar favors, free or discounted services to private patients of such requester of laboratory services to a greater extent than is provided by such requester.

(2) The following practices are excluded from the prohibitions identified in subdivision (1) of this subsection: the provision of phlebotomists to collect specimens to be sent to the laboratory for analysis, the provision of equipment or supplies that are used solely to collect, transport, process or store specimens or order or communicate the results of tests or procedures for the laboratory or the provision of specimen collection supplies needed by a physician to obtain and forward specimens for testing, or goods needed by phlebotomists to service institutions such as nursing facilities, or to make house calls or visits to other locations as directed by the requester of laboratory services.

(3) The following are prohibited as fee splitting inducements:

(A) payments of cash by a laboratory to a requester of laboratory services for referring patients or specimens;

(B) cash rebates for volume of business referred or for a period of time of referral except as permitted in subsections (b) (1) and (b) (2) of this section;

(C) payments by a laboratory to rent or lease a portion of the facilities of a requester of laboratory services not related to fair market value of the space or facilities utilized;

(D) payment of excessive fees to a requester of laboratory services for consultation, filing forms, providing standby emergency services to laboratory and blood collection facilities, or other services;

(E) payment of excessive interest by a laboratory on deposits collected for the loan of laboratory equipment;

(F) the sale of coupons, tickets or booklets, or other variations of prepayments by requesters of laboratory services that do not result in lower charges to the actual patient or recipient of laboratory services; and

(G) the purchase of corporation stock, or the purchase or rental of equipment or other tangible assets at more than fair market value by a laboratory.

(4) The following are prohibited as fraudulent practices:

(A) any written or oral agreement between a clinical laboratory and a requester of laboratory services that results in utilization of laboratory services in excess of that needed to provide information for diagnosis, prevention, treatment, or assessment of health of the patient or recipient of such services or excessive charges for these services;

(B) any system of billing or accepting payment for laboratory services that does not

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accurately identify the laboratory, the requester, the patient or recipient and the cost of such laboratory services; and

(C) any system of billing for laboratory services or issuance of receipts for payment that does not accurately indicate the amount and the recipient of such payment.

(Adopted effective June 4, 1996)

Sec. 19a-36-D37. Referral of specimens to out-of-state laboratories

(a) A Connecticut licensed laboratory may refer specimens for testing to an out-of-state clinical laboratory if the out-of-state laboratory is CLIA certified and is licensed, certified, registered, or approved in the state in which the laboratory is located, if applicable.

(b) The Connecticut licensed clinical laboratory shall maintain documentation which verifies that the out-of-state clinical laboratory, to which specimens are referred from Connecticut, meets the specimen collection, identification, examination, and reporting requirements specified in Sections 19a-36-D29 through 19a-36-D32; the referral requirements specified in subsection (a) of this section; the specimen collection, identification, urine drug testing, and reporting requirements specified in sections 31-51t through 31-51z of the Connecticut General Statutes; and the informed consent, HIV confirmation testing and confidentiality requirements specified in sections 19a-581 through 19a-590 of the Connecticut General Statutes if applicable. This documentation shall be verified as correct on a yearly basis.

(c) The laboratory shall maintain a list of out-of-state laboratories to which specimens are referred, stating the types of tests or examinations for which such specimens are submitted, which list shall be available to the department upon its request.

(Adopted effective June 4, 1996)

Sec. 19a-36-D38. Minimum standards for the operation of private clinical laboratories

(a) The laboratory shall be operated in compliance with all applicable state and federal laws and regulations, including but not necessarily limited to CLIA Title 42 Part 493 of the code of federal regulations and with all reasonable administrative directives pursuant thereto.

(b) Quarters in which laboratory work is performed or specimens collected shall be kept free from filth, excessive dirt or litter or other objectionable condition, shall be adequately lighted and ventilated, shall be equipped with utilities adequate for the work, shall be of adequate size and arrangement for the proper conduct of the work and shall be free from unnecessary safety hazards. Smoking and the consumption of food or beverages shall be prohibited in those areas where the examination of specimens is being carried out. No food or beverage shall be stored in a refrigerator or freezer used for storing patient specimens or potentially infectious materials.

(c) Equipment shall be adequate and in good order at all times as considered necessary for the proper handling of work for which licensure may be granted.

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(d) The laboratory shall at all times be operated under the supervision of a director or other qualified person acceptable to the department.

(e) No misrepresentation of the scope of laboratory services or of the qualifications or special abilities of persons associated with the laboratory shall be permitted.

(Adopted effective June 4, 1996)

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Fire Sprinkler Regulations

Sec. 19a-37a-1. Notification of sprinkler installation

Any person engaged in the installation or modification of an automatic fire extinguishing system in any building served by a public water system, as defined in subsection (a) of section 25-33d of the General Statutes, shall notify that public water system of such installation. Such persons shall be subject to all applicable rules of such public water system.

(Effective March 7, 1989; Amended December 5, 2001)

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Subject

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Birth Certificates: Filing Requirements and Access

Sec. 19a-41-1. Birth certificates: Filing requirements for births occurring outside of an institution

(a) When a birth occurs outside an institution, as defined in subdivision (2) of Section 7-47a of the Connecticut General Statutes, the birth certificate shall be prepared by the physician or nurse midwife licensed pursuant to Chapter 377 of the Connecticut General Statutes in attendance at or immediately after the birth. For purposes of this subsection the words “immediately after” mean within thirty (30) minutes. If there is no physician or licensed nurse midwife in attendance at or immediately after the birth, the father or mother shall complete a draft birth certificate, also called a worksheet, which he or she may obtain from the town registrar of vital statistics. The completed certificate of live birth, or worksheet with the documentation described in this subsection, shall be filed with the registrar of vital statistics in the town in which the birth occurred or the town in which the newborn child is first removed from a moving conveyance in accordance with subdivision (d) of Section 7-48 of the Connecticut General Statutes, not later than ten (10) days after the birth. Prior to preparation and filing of such certificate, the father or mother shall verify the fact and circumstances of that birth by providing to the town registrar of vital statistics documentation of:

(1) proof of pregnancy to include either:

(A) a signed and dated report from either the physician or clinic that provided prenatal care to the mother; or

(B) notarized affidavits provided by two (2) adults, other than the father and mother, having firsthand knowledge of the pregnancy; or

(C) a signed and dated report from either the physician or clinic that provided postpartum care to the mother within twenty-four (24) hours after the birth; and

(2) proof of live birth to include:

(A) a notarized affidavit by the mother attesting to the date, time, and place of such live birth and, if any other adult witnessed the birth, a notarized affidavit by one such adult; and

(B) a signed and dated report from either the physician or clinic providing medical care to the newborn within twenty-four (24) hours after the birth.

(b) When the documents required in subsection (a) of this section are submitted to the town registrar of vital statistics, such registrar shall either file the certificate of live birth prepared by a physician or licensed nurse midwife, or prepare the certificate from the worksheet and file such certificate. It shall be signed by the person assisting in the delivery of the infant, or, in the absence of such person, the father or the mother.

(Adopted effective March 4, 1996)

Sec. 19a-41-2. A certified copy of or access to birth certificates

(a) Anyone requesting a copy of, or permission to examine the original or copy of, a birth certificate or birth record in the custody of any registrar of vital statistics or the Department of Public Health shall provide proof, as specified in subsection (b) of this

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section, that the person is eligible to receive or examine such certificate or record under Section 7-51 of the Connecticut General Statutes.

(b) The person whose birth is recorded, if over eighteen (18) years of age, or other requester as authorized by section 7-51 of the Connecticut General Statutes shall submit a valid, government issued photographic identification that includes the person's or requester's date of birth, signature, and an expiration date. Should such photographic identification be unavailable, originals or photocopies of the following documents shall be substituted for it. Unless otherwise indicated, such person or requester shall provide the documents listed in two (2) of the following subdivisions. If a registrar or the department has reason to doubt the authenticity of a document presented by such person or requester, such registrar or the department may request any additional document listed in subdivisions (1) to (15), inclusive, of this subsection:

- (1) social security card;
- (2) social security card supplemented with either an employment identification card, a paycheck stub or a W-2 form. Providing the documents in this subdivision fully satisfies the identification requirements of this section;
- (3) automobile registration;
- (4) copy of utility bill showing name and current address;
- (5) checking account deposit slip or bank statement stating name and current address;
- (6) voter registration card;
- (7) valid government issued trade or professional license;
- (8) valid government issued firearm permit;
- (9) probation documents issued by a court or other government agency, pursuant to a criminal conviction;
- (10) letter from a government agency verifying identity. The letter shall be dated within six months prior to the date of the request;
- (11) release documentation from a correctional institution containing a photograph of the former inmate and a release date within 12 months prior to the date of the request;
- (12) birth certificate of the requester;
- (13) military discharge papers;
- (14) current school or college photographic identification; or
- (15) government issued photographic identification that has expired within 12 months prior to the date of the request.

(Adopted effective March 4, 1996; Amended January 3, 2011)

Sec. 19a-41-3. Belated registration of birth

(a) Any person making an affidavit under Section 7-57 of the Connecticut General Statutes for the preparation and filing of a belated certificate of birth shall include the following information on the individual whose certificate is being requested:

- (1) first, middle, and last name;
- (2) sex;

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- (3) date of birth;
- (4) place of birth;
- (A) town;
- (B) county; and
- (C) hospital name or address of out-of-hospital birth;
- (5) mother's maiden name; and
- (6) father's full name.
- (b) A belated registration of birth shall not be prepared for any deceased person.

(Adopted effective March 4, 1996)

Sec. 19a-41-4. Electronic vital records

(a) **Definitions.** As used in this section:

(1) "Authentication of an electronic vital record" means affixing to a vital record transmitted to the department via an electronic vital records system the user identification, password or other means of electronic identification, as incorporated in the electronic vital records system, of the creator of the record or his designee. By affixing an assigned user identification, password or other means of electronic identification, as incorporated in the electronic vital records system, to a record transmitted electronically to the department, the creator or the creator's designee affirms that he or she is the transmitter of the record and that the information transmitted is authentic. The department may from time to time incorporate in the electronic vital records system such other means of electronic identification based on the ability of such means to establish the identity of each user of the system.

(2) "Authorized entity" means any person, facility or institution, which is authorized by the department to transfer an electronic vital record through a controlled process, including but not limited to the following persons or institutions:

- (A) Local Registrars as defined by section 7-36 of the Connecticut General Statutes
- (B) Health care facility personnel affiliated with certifying births and deaths
- (C) Funeral Directors and Embalmers licensed by the State of Connecticut
- (D) Chief Medical Examiner

Authorization shall be approved by the department in writing, on a form supplied by the department. Upon approval, the department shall provide an authorized entity with a security identification code and password to access the system. The department may revoke authorization if it is determined that the authorized entity is not abiding by the controlled process as described in subsection (c) of this section.

An authorized entity may approve a designated individual to electronically create and transmit vital records to the department and to the local registrars of vital statistics. The designee shall be an individual whose regular work duties include assisting the authorized entity in creating and transmitting vital records. Authorization for the designee shall be granted in writing upon a form supplied by the department. The department shall also sign such form for final approval of the authorization. Upon approval, the department shall

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provide the designee with a security code and user identification code and password to access the system.

(3) “Commissioner” means the commissioner of public health.

(4) “Controlled process” means a department approved, written administrative protocol that defines how an authorized entity protects the integrity and confidentiality of vital records that are electronically transmitted, and includes the criteria set forth in subdivision (4) of subsection (c) of this section.

(5) “Department” means the department of public health.

(6) “Electronic” means relating to technology having electrical, digital, magnetic, wireless, optical, electromagnetic, or similar capabilities.

(7) “Electronic signature” means an electronic sound, symbol, or process attached to or logically associated with a record and executed or adopted by a person with the intent to sign the record.

(8) “Electronic vital record” means a vital record created, amended, stored, generated, received or communicated by electronic means by the department or an authorized entity.

(9) “Electronic vital records system” means a system used by the department to electronically collect and transmit vital statistics data and which is designed to ensure that data is not corrupted in the transmission process.

(10) “Local registrar of vital statistics” means the local registrar of births, marriages and deaths or any local public official charged with the care of returns relating to vital statistics as defined in section 7-36 of the Connecticut General Statutes.

(11) “Superintendent of registration of vital statistics” means the commissioner of public health as defined in section 19a-40 of the Connecticut General Statutes.

(12) “Vital record” means a certificate of birth, death, fetal death or marriage as defined in section 7-47a(3) of the Connecticut General Statutes.

(b) Applicability

This section applies to the recording, preserving, indexing, amending, reproducing or transmitting of data, certificates, forms, documents, copies, indices, and files and the issuance of certified copies of vital records as authorized by Chapter 93 and sections 19a-40 through 19a-45 of the Connecticut General Statutes.

(c) Electronic Vital Records Allowed

(1) A vital record may be submitted electronically in a retrievable form through the electronic vital records system.

(2) Any vital record that requires a manual, facsimile or other form of signature or that is given effect with a manual, facsimile or other form of signature may be signed or given effect with an electronic signature. Such electronic signature has the same force and effect as a manual, facsimile or other form of signature.

(3) Only an authorized entity may electronically transmit vital records in this state. Such entity or its department approved designee, as described in subsection (a)(2) of this section, shall electronically create and transmit vital records to the department and to the local registrars of vital statistics.

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(4) An authorized entity may create, store, access and transmit any electronic vital record only through a controlled process. Such process shall ensure the accuracy and integrity of an electronic record during its creation, storage, usage and transmission and shall include steps for:

(A) Ensuring that electronic vital records are secure, including a means of establishing their chain of custody;

(B) Safeguarding the confidentiality of electronic vital records and preventing access to them by unauthorized persons;

(C) Detailed record keeping to allow for auditing by and accountability to the department;

(D) Ensuring that, for each electronic vital record, a single, unique, identifiable record exists;

(E) Ensuring that electronic vital records may be altered only in accordance with sections 19a-42 and 7-42 of the Connecticut General Statutes and applicable sections of the Regulations of Connecticut State Agencies;

(F) The authentication of electronic vital records and for ensuring that the user identification of each user of the controlled process is unique and incontrovertible; and

(G) Ensuring that there is at all times a designated custodian of the electronic vital records system.

The department shall provide a standardized controlled process that shall be signed by the authorized entity and returned to the department. If the standardized controlled process conflicts with the established business practices of the authorized entity, the authorized entity may modify the controlled process to suit its business needs. The modified controlled process shall be signed by the authorized entity, and submitted to the department for approval. The department shall notify the authorized entity in writing, whether the modified controlled process is accepted or refused.

(5) The department shall use the system for the receipt and transmittal of electronic vital records. Such system shall be the central repository of electronic vital records for the State of Connecticut.

(6) The local registrar of vital statistics shall be the custodian of the originals of the paper or microfilm version of the vital records that he or she creates and shall issue certified copies of vital records from the electronic vital record system, when applicable, or the paper vital records or microfilmed vital records in his or her custody.

(d) The Relationship between this Section and Regulations Adopted Pursuant to Section 1-264 of the Connecticut General Statutes.

In the event of a conflict between any provisions of this section and the provisions of any regulation the Department of Information Technology adopts pursuant to section 1-264 of the Connecticut General Statutes, the provisions of the regulations of the Department of Information Technology shall prevail, except where the inconsistency results from a specific requirement of the vital records statutes, sections 7-36 through 7-76, inclusive, and sections 19a-40 through 19a-45, inclusive, of the Connecticut General Statutes, in which case the

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provisions of the vital records statutes shall prevail.

(Adopted effective December 5, 2001)

Amendments and Corrections to Vital Records

Sec. 19a-41-5. Definitions

For the purposes of sections 19a-41-6 through 19a-41-11, inclusive of the Regulations of Connecticut State Agencies:

(1) “Medical Examiner” means any physician licensed to practice medicine in this state who is employed by the Office of the Chief Medical Examiner for the purpose of investigating and certifying the cause and manner of death. For the purpose of these regulations, “medical examiner” does not include physicians who perform the duties of a medical examiner through a contractual agreement with the Department of Administrative Services;

(2) “Certifier” means the practitioner who attests to the cause and manner of death and signs the death certificate.

(Adopted effective August 1, 2005)

Sec. 19a-41-6. General instructions for amending and correcting vital records

If a vital record is electronically filed, amendments and corrections shall be completed through methods incorporated into the electronic vital records system. If the original source of the vital record is in a paper format, the local registrar shall insert the information that was left incomplete, or in the case of inaccurate information, type a single line through the data that is to be changed. The added or modified information shall be typed onto the certificate in the box designated for such information. If a document is bound, the changes shall be legibly printed in black ink. In the alternative, a vital record in paper format may be corrected or amended by converting the certificate to an electronic format, if such electronic format is available. For all corrections, as defined in section 7-36 of the Connecticut General Statutes, the date of the correction and a summary description of the evidence submitted in support of the correction shall be maintained as part of the record. For all amendments, as defined in section 7-36 of the Connecticut General Statutes, excluding amendments related to parentage, gender change or cause of death, the word “Amended” shall be recorded on the face of the certificate along with the item category, the information that was changed, the date of the amendment, and a description of the documentation provided to support the amendment. The documentation provided to support the amendment or the correction shall be maintained in an evidence file.

(Adopted effective August 1, 2005)

Sec. 19a-41-7. Supporting documentation for amendment or correction. Due process when request for amendment or correction is denied

A registrar of vital statistics shall amend or correct a vital record upon the written request

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of a party authorized under section 19a-41-8 of the Regulations of Connecticut State Agencies to make such request when the party provides documentation to support the requested change. Only unaltered documents will be accepted. In addition to documentary evidence, the requesting party shall also provide an affidavit affirming that the existing vital record is incorrect or incomplete, and that the newly provided information is accurate. A registrar shall waive the requirement of an affidavit when the party requesting the amendment or correction is the funeral director, birth registrar, or certifying practitioner who created the vital record. The registrar shall evaluate the supporting documentation. If the documentation justifies the requested change, the registrar shall amend or correct the record as requested, and maintain the supporting documentation and the written request in an evidence file. If the registrar finds reason to doubt the validity of the documentation, or if the documentation is not adequate to support the requested amendment or correction, the registrar shall deny the request in writing. In such a case, the local registrar shall notify the applicant in writing that the applicant may request that the Department review the matter. The local registrar shall send a copy of the denial letter to the Department. On the applicant's request, the State Registrar of Vital Records shall review the information. If the State Registrar of Vital Records finds that the submitted documentation is authentic and supports the requested change, the State Registrar shall amend or correct the vital record to reflect the change. If the State Registrar of Vital Records finds that the documentation is not authentic or that it does not support the requested change, the State Registrar shall deny the request and notify the applicant in writing of the denial. The Department shall also notify the applicant in writing that the applicant has the right to a hearing on the matter. The hearing shall be held in accordance with Chapter 54 of the Connecticut General Statutes and sections 19a-9-1 to 19a-9-29, inclusive, of the Regulations of Connecticut State Agencies. If the hearing officer finds that the submitted documentation is authentic and supports the requested change, the State Registrar shall amend or correct the vital record to reflect the change.

(Adopted effective August 1, 2005)

Sec. 19a-41-8. Who may apply to modify a vital record

(a) The local registrar at the town of occurrence or the State Registrar may correct or amend obvious errors, omissions, or transpositions of letters in words of common knowledge, upon his or her own observation or query.

(b) An individual responsible for filing a birth certificate may request in writing the correction or amendment of the certificate. In addition, a registrant, if over 18 years old, may request in writing a correction or amendment of the registrant's own birth certificate. A custodial parent or legal guardian of a minor child may request in writing the correction or amendment of the child's birth certificate. Only a registrant over 18 years old, or a custodial parent or legal guardian of a minor registrant, may request the amendment of a birth certificate to reflect the registrant's gender change. Only the commissioner shall make amendments pertaining to adoption, gestational agreements, or maternity upon receipt of a

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court order. Only the commissioner shall make amendments related to paternity based on a court order or on a voluntary acknowledgement of paternity.

(c) A custodial parent, the certifier, medical examiner or funeral director may apply for the modification of a fetal death certificate.

(d) Both parties to a marriage shall apply jointly to modify a license and certificate of marriage or an affidavit recorded pursuant to subsection (b) of section 46b-34 of the Connecticut General Statutes, except that, where one spouse is deceased, the surviving spouse may apply individually for the modification of such license and certificate or affidavit. A party to an annulled or dissolved marriage may only apply for the modification of items on the marriage certificate relating to such party.

(e) The next of kin, the informant, certifier, medical examiner, or funeral director named on a death certificate may apply for the modification of a death certificate. Only the Office of the Chief Medical Examiner or the practitioner who originally certified the cause of death, may apply for a modification to the cause of death. In the absence or inability of the certifying practitioner, or with his or her approval, the cause of death may be amended upon receipt of a signed statement from an associate practitioner approved to certify the cause of death in accordance with section 7-62b of the Connecticut General Statutes, or the chief medical officer of the institution in which the death occurred, provided such individual has access to the medical history of the case.

(f) Except as otherwise specified by statute, no information shall be removed or otherwise changed on a vital record if such information is known to be accurate.

(Adopted effective August 1, 2005)

Sec. 19a-41-9. Amending or correcting birth records: Corrections within one month of filing birth certificate, legal name change, correcting obvious errors to registrant's name, adoptions, paternity, gender change

(a) The local registrar of the town where a birth occurred or the Department shall amend a name on a birth certificate when the request for the amendment is accompanied by a certified copy of a court order granting the legal name change. The registrar or the Department shall place the new name on the birth certificate in accordance with the provisions of these regulations, and shall mark the birth certificate "Amended." The registrar or the Department shall record on the face of the certificate the original name of the person, the authority by which such legal name change was granted, and the date of the amendment.

(b) For up to 30 days following a registrant's birth, a parent may request that the registrant's name be changed to correct an obvious typographical or clerical error, by signing and presenting to the local registrar of the town in which the birth occurred, the Parent Notice issued by the birthing hospital. After said thirty-day period, a registrant, if over eighteen years old, or a custodial parent or legal guardian of the registrant, if the registrant is a minor, may request that the registrant's name be changed to correct or amend obvious typographical or clerical errors, by presenting two items of documentary evidence that were produced during the registrant's early childhood, from birth through age 7. The following

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documents are acceptable in their original form:

- (1) Newspaper announcement of registrant's birth;
- (2) Computer printout of registrant's application for a Social Security number;
- (3) Early childhood insurance policy application;
- (4) Early childhood savings bond;
- (5) Federal census;
- (6) Certified copy of a sibling's or parent's birth certificate (last name spelling correction only);
- (7) Certified copy of parents' marriage certificate (last name spelling correction only);
- (8) Official legal document showing mother's or father's last name, such as a passport, issued no later than the registrant's date of birth (last name spelling correction only);
- (9) Letter from hospital where registrant was born verifying that a clerical error was made;
- (10) Other documents as approved by the State Registrar of Vital Records.

If a record or document containing proof of the registrant's correct name exists but the requester is unable to present the document in its original form, a duly certified copy, or an attested copy signed by the custodian of the record or document, may be submitted as proof of the registrant's correct name. The document must have been produced during the registrant's early childhood, from birth through age 7. This procedure may be used to submit evidence from the following types of records:

- (11) Early childhood baptismal record;
- (12) Early childhood physician record;
- (13) Early childhood hospital, clinic or nursery record;
- (14) Application for day care or nursery;
- (15) Early childhood elementary school record (kindergarten or 1st grade);
- (16) Early childhood census record;
- (17) Other documents as approved by the State Registrar of Vital Records.

A local registrar shall contact the Department to obtain approval to accept a document for proof of evidence for any document not listed in subdivision (1) through (16) of this section. The Department may grant approval either verbally or in writing.

(c) Only the commissioner may amend a birth certificate related to an adoption. The commissioner shall replace the original birth certificate on receipt of a certified copy of a Record of Adoption (VS-51) or Out-of-State Record of Adoption (VS-51a), along with a certified copy of the adoption decree, with a new certificate of birth created in accordance with sections 7-53-1 to 7-53-3, inclusive of the Regulations of Connecticut State Agencies. In the case of a foreign birth adoption, the commissioner shall create a Certificate of Foreign Birth or Certification of Birth Registration upon the written request of the adoptive parent, along with a certified copy of a Record of Adoption (VS-51) for a foreign birth adoption finalized in the United States that names a Connecticut resident as the adoptive parent or upon receipt of a certified copy of a Connecticut probate court order authenticating a foreign birth adoption finalized outside of the United States.

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(d) Only the commissioner shall amend a birth certificate to include or change paternity information on a birth certificate. Upon receipt of a notarized acknowledgement of paternity form signed by both parents or a certified copy of an adjudication of paternity, the commissioner shall create a new birth certificate to show the father's name on the birth certificate. The new birth certificate shall not be marked "Amended." If another father is already listed on the original birth certificate, a new birth certificate may only be prepared when an adjudication of paternity is made by a court of competent jurisdiction. A new birth certificate shall be created by entering the new paternity information into the electronic birth registry system, and by changing the name of the child if so indicated on the acknowledgement of paternity form or within the certified court order that establishes paternity. The new certificate shall be used to issue certified copies. The commissioner shall place the original birth certificate and the acknowledgement of paternity form or court order in a confidential file. A certified copy of the amended certificate shall be sent either through mail or electronically to all local registrars of vital statistics who have the original certificate on file, along with a letter informing the local registrar that the original birth certificate has been amended for reasons of paternity, and instructing the local registrar to place the original birth certificate in a confidential file. Access to confidential paternity files maintained at the State and local vital records offices, and the information contained within such files, shall be restricted to the registrar, designated staff members, or to other parties upon an order of a court of competent jurisdiction.

(e) Only the commissioner shall amend a birth certificate to reflect a gender change. In order to request a gender change amendment the following documents shall be submitted to the commissioner:

(1) Affidavit from a licensed psychiatrist, psychologist or clinical social worker performing a psycho-social evaluation, attesting to the fact that the registrant is socially, psychologically and mentally the designated sex;

(2) Affidavit from the surgeon performing the sex change operation, attesting to the fact that the surgery was performed;

(3) Court order for legal name change if applicable.

Upon receipt of the required documentation, the commissioner shall create a new birth certificate reflecting the newly assigned gender, and the legal name change if applicable. The new certificate shall not be marked "Amended" and shall be used to issue certified copies. The original birth certificate, and the supporting documentation shall be placed in a confidential file. A certified copy of the amended certificate shall be sent either through mail or electronically to all local registrars of vital statistics who have the original certificate on file, along with a letter informing the local registrar that the original birth certificate has been amended due to gender change, and instructing the local registrar to place the original birth certificate in a confidential file. Access to confidential files for gender change amendments maintained at the State and local vital records offices, and the information contained within such files, shall be restricted to the registrar, designated staff members, or to other parties upon an order of a court of competent jurisdiction.

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(f) To amend the date or time of birth, or the child's birth weight, an applicant shall provide documentation from the clinician attending the birth or an administrator of the hospital of which the birth occurred, supporting the proposed amendment.

(Adopted effective August 1, 2005)

Sec. 19a-41-10. Death records: Amending cause-of-death information

(a) When existing language on a standard death certificate (VS-4) requires amendment due to a change in the original cause-of-death diagnosis, the practitioner who provided the original medical certification shall submit a letter to the local registrar of the town where the death occurred, indicating the correct cause of death. The letter shall be written on the practitioner's professional stationery and signed and dated by such practitioner. In the absence or inability of the certifying practitioner or with such practitioner's approval, the cause of death may be amended upon receipt of a signed statement, on the hospital's or practitioner's professional stationery, from an associate practitioner approved to certify the cause of death in accordance with section 7-62b(c) of the Connecticut General Statutes, or the chief medical officer of the institution in which the death occurred provided such individual has access to the medical history of the case. The state or local registrar may require documentary evidence to substantiate the requested amendment. The Office of the Chief Medical Examiner may also correct the cause-of-death information on a standard death certificate by issuing to the local registrar of the town where the death occurred, a Medical Examiner death certificate (VS-4 ME) listing the correct cause-of-death, along with a letter instructing the registrar to replace the standard death certificate with the Medical Examiner death certificate containing the correct medical diagnosis.

Upon receipt of proper documentation, the local registrar of the town where the death occurred shall amend the original death certificate by drawing a single line through the original cause-of-death information, and typing the correct medical diagnosis, or by entering the corrected data in an electronic death registry system if such system is available to the local registrar. The local registrar shall record the word "Amended" on the face of the original death certificate, along with a description of the item that was amended, and the date of the amendment. If a private practitioner initiates the amendment, the local registrar shall create a new death certificate by typing all the information from the original death certificate onto a blank standard death certificate, or by entering the data into the electronic death registry system, except that the corrected cause-of-death information shall be substituted for the original cause-of-death information. If the amendment is initiated by the medical examiner, the local registrar shall complete the Medical Examiner death certificate received from the Office of the Chief Medical Examiner listing the new cause of death, by entering all other information as stated on the original standard death certificate. All dates are to remain the same as on the original death certificate, except that the "Certificate Received for Record" date shall reflect the new receipt date. The new death certificate shall contain the signatures of the practitioner or medical examiner, and the funeral director who signed the original death certificate. If the registrar cannot obtain the signature of the

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practitioner, medical examiner or funeral director the registrar shall insert the name of the practitioner, medical examiner, or funeral director in the appropriate spaces. The registrar shall not mark the new certificate “Amended.”

The local registrar shall send either by mail or electronically, an authenticated copy of the new certificate to the Department and to the local registrar of the decedent’s town of residence at the time of death, along with a letter explaining that the certificate being sent is a replacement certificate for the original death certificate already on file. If the death certificate is a paper certificate, the registrar shall send the original death certificate and the documentation requesting and supporting the change to the Department for placement in a confidential file. Only the commissioner may order the confidential record unsealed. Upon receipt of the amended death certificate, the Department and the local registrar of the town of residence shall replace the original death certificate with the new death certificate. When a certified copy of the death certificate is requested, the registrar or the Department shall issue a certified copy of the new death certificate.

(b) Amendments to cause-of-death information on a Medical Examiner death certificate (VS-4ME) shall be changed only upon the request of the Chief Medical Examiner’s Office. To amend a cause of death listed as “Pending,” the Chief Medical Examiner’s Office shall submit a Correction Form (VS-35) to the local registrar of the town where the death occurred, indicating the actual cause-of-death diagnosis.

Upon receipt of a Correction Form, the local registrar shall enter the new information in the electronic death registry system if available, or in the case of paper death certificates, type or draw a line through the word, “Pending”, and insert the cause-of-death information and any additional information into the appropriate boxes as listed on the Correction Form. The registrar shall place the word “Amended” on the face of the original death certificate, along with the item number that was amended, the date of the amendment, and the phrase ‘per Medical Examiner.’ Not later than ten days after the registrar amends the original death certificate, the local registrar shall send either through mail or electronically, an authenticated copy of the amended death certificate to the Department. If the copy is in paper format, the registrar shall send the authenticated copy separately from the regular monthly batch of vital records sent to the Department. The local registrar shall also send either through mail or electronically, an authenticated copy of the amended death certificate to the decedent’s town of residence at the time of death. The Correction Form shall be kept on file at the town of occurrence.

(Adopted effective August 1, 2005)

Sec. 19a-41-11. Amending race information on vital records

(a) The local registrar of the town where the vital event occurred or the Department shall correct or amend race information on a vital record upon the request of an eligible party as specified in section 19a-41-8 of these regulations. The party requesting the modification shall provide documentation supporting the requested change. The following documentation is acceptable to support a change in race information:

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- (1) a certified copy of a certificate of birth for the registrant's ancestor; or
- (2) certification by a state or federally recognized Indian tribe that the registrant is a member of a tribe; or
- (3) other documents as approved by the State Registrar of Vital Records.

A local registrar shall contact the Department to obtain approval to accept a document for proof of evidence for any document not listed in this subsection. The Department may grant approval either verbally or in writing.

(Adopted effective August 1, 2005)

Sec. 19a-41-12. Amendment of the same item more than once

Once an amendment of an item is made on a vital record, that item shall not be amended again except upon receipt of a court order from a court of competent jurisdiction.

(Adopted effective August 1, 2005)

Sec. 19a-41-13. Application for marriage license

Each person applying for a marriage license shall provide the local registrar of vital statistics with a valid, government issued photographic identification that includes the applicant's date of birth, signature and an expiration date. Should a photographic identification be unavailable, then the originals or photocopies of the following documents shall be substituted. Unless otherwise indicated, the applicant shall provide the documents listed in two (2) of the following subdivisions. If the registrar has reason to doubt the authenticity of a document presented by the applicant, the registrar may request any additional document listed in subdivisions (1) to (15), inclusive of this subsection:

- (1) social security card;
- (2) social security card supplemented with either an employment identification card, a paycheck stub or a W-2 form. Providing the documents in this subdivision fully satisfies the identification requirements of this section;
- (3) automobile registration;
- (4) copy of utility bill showing name and current address;
- (5) checking account deposit slip or bank statement stating name and current address;
- (6) voter registration card;
- (7) valid government issued trade or professional license;
- (8) valid government issued firearm permit;
- (9) probation documents issued by a court or other government agency, pursuant to a criminal conviction;
- (10) letter from a government agency verifying identity. The letter shall be dated within six months prior to the date of the request;
- (11) release documentation from a correctional institution containing a photograph of the former inmate and a release date within 12 months prior to the date of the request;
- (12) birth certificate of the applicant;
- (13) military discharge papers;

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- (14) current school or college photographic identification;
 - (15) government issued photographic identification that has expired within 12 months prior to the date of the request; or
 - (16) other documents as approved by the State Registrar of Vital Records.
- (Adopted effective January 3, 2011)

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Subject

Newborn Infant Health Screening

Inclusive Sections

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Newborn Infant Health Screening

Sec. 19a-55-1. Newborn infant health screening

(a) The administrator or other person in charge of any institution providing medical care of newborn infants twenty-eight days of age or younger shall cause to be taken from every newborn infant in its care a blood specimen for tests pursuant to section 19a-55 of the Connecticut General Statutes.

(b) A newborn infant shall be tested for the following: phenylketonuria and other metabolic diseases, hypothyroidism, galactosemia, sickle cell disease, maple syrup urine disease, homocystinuria, biotinidase deficiency, congenital adrenal hyperplasia, amino acid disorders, organic acid disorders and fatty acid oxidation disorders, including, but not limited to, 3-Hydroxy Long-Chain ACYL-CoA Dehydrogenase Deficiency (LCHADD), Medium-Chain ACYL-CoA Dehydrogenase Deficiency (MCADD), Tyrosine and such other tests for inborn errors of metabolism as shall be prescribed by the Commissioner of Public Health.

(c) Testing shall be subject to the following conditions:

(1) Materials for the collection of the specimen and forms to accompany the specimen shall be of a type furnished by or acceptable to the Department of Public Health.

(2) The specimen shall be collected prior to the newborn's discharge from the institution. If the newborn is discharged prior to 24 hours of life, the specimen shall be collected as close to the time of discharge as practicable. If the newborn's medical condition permits, the specimen shall be collected before the fourth day of life, transfer to another institution, transfusion of blood or blood products, or dialysis. If the newborn expires before discharge from the institution, the specimen shall be collected as soon as practicable after death.

(3) Each specimen shall be submitted within forty-eight (48) hours after collection to the Department of Public Health Laboratory, or to a laboratory approved by the Department of Public Health.

(4) Information accompanying each specimen shall identify for future reference the newborn from whom the specimen was taken, the time and date of birth, the time and date of specimen collection, by whom the specimen was collected, and the primary care provider after discharge from the institution.

(5) Laboratory tests shall be performed by methods approved by the Department of Public Health.

(6) Records of tests shall clearly indicate the disorders tested for, and the results thereof, and shall be maintained for a minimum of five years.

(7) The primary care provider identified in subdivision (4) of this section shall receive notification of any abnormal test result.

(8) Each specimen shall be stored at the laboratory of the Department of Public Health for not less than six months after testing.

(Adopted effective September 1, 2006)

Sec. 19a-55-2. Administration of HIV related test

(a) The administrative officer or other person in charge of each institution caring for

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newborn infants shall cause to have administered to every such infant in its care an HIV-related test, as defined in section 19a-581 of the Connecticut General Statutes, if the mother has not had an HIV-related test pursuant to section 19a-90 or 19a-593 of the Connecticut General Statutes. It shall be administered:

- (1) by the institution caring for the newborn infant, and
- (2) as soon after the birth as is medically appropriate.

(Adopted effective September 1, 2006)

Sec. 19a-55-3. Objection of parents to newborn infant health screening

If the parents or legal guardians of a newborn infant object to newborn infant health screening as being in conflict with their religious tenets and practice, such objection shall be reported on a waiver form provided by the Department of Public Health. The parents or legal guardians shall sign the waiver form. The original shall be placed in the newborn infant's medical record, and a copy submitted with the newborn infant's unused specimen collection materials to the Department of Public Health Laboratory.

(Adopted effective September 1, 2006)

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Subject

Newborn Hearing Screening Program

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Sec. 19a-59-1. Newborn hearing screening program

Newborn Hearing Screening Program

Sec. 19a-59-1. Newborn hearing screening program

(a) Not later than July 1, 2000, each institution as defined in section 19a-490 of the Connecticut General Statutes that provides childbirth services shall develop and implement a universal newborn hearing screening program which shall at a minimum include the following:

(1) A physiologic technologies testing mechanism which employs automated or diagnostic auditory brainstem response (ABR) or otoacoustic emissions (OAE), or subsequently developed or improved physiologic technologies that substantially enhance newborn hearing assessment that are recognized by the American Academy of Audiology or American Speech Language Association; and

(2) a mechanism for monitoring the institution's compliance with the newborn hearing screening program which shall include, but not necessarily be limited to, the following information:

(A) name of each newborn infant;

(B) date of birth;

(C) date infant received hearing screening or documentation of parent refusal for newborn hearing screening;

(D) method of screening;

(E) results of screening;

(F) person performing screening; and

(G) to whom referral for further evaluation was made, if applicable.

(b) A parent who refuses to allow his or her infant to be screened for a hearing impairment based upon religious tenets and practice shall sign a statement attesting to said refusal which shall include a statement by a licensed health care provider that the parent was informed of the medical consequences of such refusal. The document shall identify the specific reasons for the refusal and shall be placed in the infant's medical record. If a parent declines to sign the refusal statement, the institution shall document in the infant's medical record the reason for the refusal by the parent to permit newborn hearing screening and a statement that the parent refused to sign the document and was informed of the medical consequences of such refusal.

(c) Documentation of the screening shall be maintained in the infant's medical record and shall be retained for a minimum of twenty-five (25) years after discharge of the infant except that original medical records may be destroyed sooner if they are microfilmed by a process approved by the department.

(d) The institution shall develop and implement policies and procedures for the requirements of this section which shall be reviewed and approved by the institution's medical staff and governing body.

(e) The department may review implementation of Section 19a-59-1 of the Regulations

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of Connecticut State Agencies at the time of licensure inspections.

(Adopted effective March 4, 1999; Amended April 10, 2000)

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Subject

Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

Inclusive Sections

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Sec. 19a-59c-4.	Local WIC agency participation
Sec. 19a-59c-5.	Food vendor participation
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Special Supplemental Nutrition Program for Women, Infants and Children (WIC)

Sec. 19a-59c-1. Definitions

As used in Sections 19a-59c-1 to 19a-59c-6, inclusive, of the Regulations of Connecticut State Agencies:

(a) “Allowable Costs” means “food costs” and “administrative and program services costs” in accordance with 7 CFR 246.14.

(b) “Applicant” means a person who appears in person at the local WIC office to request WIC program benefits.

(c) “Authorized Foods” means foods authorized by the department for purchase with WIC checks.

(d) “Authorized Vendor” means a food store or pharmacy that has met the minimum qualifications for participation and has been approved for authorization by the Connecticut WIC Program and has entered into a duly executed contract with the Department of Public Health.

(e) “Breastfeeding Women” means women up to one year postpartum who are breastfeeding their infants an average of at least once per day.

(f) “Caseload Management” means the process of distributing the program resources to the neediest individuals.

(g) “Category” means an indication of whether an individual is a pregnant woman, breastfeeding woman, postpartum woman, infant or child.

(h) “Categorical Eligibility” means persons who meet the definitions of pregnant women, breastfeeding women, postpartum women, or infants or children.

(i) “Certification” means the implementation of criteria and procedures to assess and document each applicant’s eligibility for the program.

(j) “Certified” means that an applicant has been determined eligible by a Competent Professional Authority to receive program benefits.

(k) “Certification Period” means the period which begins on the date the individual is certified. Duration of the certification period is defined as follows:

(1) for pregnant women - the duration of pregnancy and up to six weeks postpartum,

(2) for postpartum women - up to six months after the termination of pregnancy,

(3) for breastfeeding women - intervals of approximately six months and ending with the breastfed infant’s first birthday,

(4) for infants and children - approximately six months. Infants under six months of age may, when authorized by the department, be certified for a period extending up to their first birthday.

(l) “Children” means persons who have had their first birthday but have not yet attained their fifth birthday.

(m) “Commissioner” means the Commissioner of the State Department of Public Health.

(n) “Competent Professional Authority (CPA)” means a physician licensed in Connecticut, nutritionist, dietitian, registered nurse licensed in Connecticut, Physician’s assistant as defined in Section 20-12a, as amended, of the general statutes.

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(o) “Contract Account” means any line item of the local agency budget annexed to the local agency contract.

(p) “Coordinated Program” means a program of dietetic training approved by the American Dietetic Association that provides for the integration of didactic instruction with a minimum of 900 hours of supervised dietetic practice within an academic program.

(q) “Denial” means the act of refusal to accept an application for participation of an individual applicant, food vendor, or local agency.

(r) “Days” means calendar days.

(s) “Department” means the State Department of Public Health.

(t) “Dietitian” means an individual who is registered by the Commission on Dietetic Registration of the American Dietetic Association or who is eligible to take the registration examination.

(u) “Dietetics” means a health science concerned with the application of nutrition principles and services to achieving individuals’ health throughout life and in the treatment of disease.

(v) “Disqualification” means the act of ending the Program participation of a participant for the remainder of the certification period; an authorized food vendor for a specified period of time; or contracted local agency for the remainder of the contract period. Disqualification may be done for either a punitive sanction or for administrative reasons.

(w) “Dual Participation” means simultaneous participation in the program in one or more than one local agency during the same period of time.

(x) “Potential Dual Application Report” means a computer generated list used by the State WIC Program to identify actual and possible simultaneous participation in more than one local agency.

(y) “Enrolled” means certified by a CPA and listed by a local agency to receive benefits subject to availability of funds.

(z) “Equipment” means tangible personal property having a useful life of more than one year and an acquisition cost of \$100.00 or more per unit.

(aa) “Family” means a group of related or nonrelated individuals who are not residents of an institution but who are living together as one economic unit except that residents of a homeless facility should not be considered as a single family.

(bb) “Food Delivery Systems” means the methods used by the State WIC Program to provide supplemental foods to participants.

(cc) “Food Instrument” means a check which is used by a participant to obtain supplemental foods.

(dd) “General Waiting List” means a list of individuals who have not been certified, but who are potentially eligible to receive WIC benefits.

(ee) “High Risk Criteria” means nutritional risk criteria defined in the State WIC Manual, as amended.

(ff) “High Risk Participant” means a participant presenting with one or more high risk criteria.

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(gg) “Homeless Individual” means:

(1) an individual who lacks a fixed and regular nighttime residence; or

(2) an individual whose primary nighttime residence is:

(A) a supervised publicly or privately operated shelter (including a welfare hotel or congregate shelter) designed to provide temporary living accommodations; or

(B) an institution that provides a temporary residence for individuals intended to be institutionalized; or

(C) a temporary accommodation in the residence of another individual not to exceed 365 days; or

(D) a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

(hh) “Indirect Costs” means costs which are (i) incurred for a common or joint purpose benefiting more than one cost objective, and (ii) not readily assignable to the cost objectives specifically benefited, without effort disproportionate to the results achieved. This term applies to costs of this type originating in the grantee department, as well as those incurred by other departments in supplying goods, services, and facilities, to the grantee department.

(ii) “Infants” means persons under one year of age.

(jj) “Local Agency” means an administrative unit of a health or human service agency, public or private, under contract with the State of Connecticut Department of Public Health to administer the WIC Program in a designated area of the State.

(kk) “Migrant” means an individual whose principal employment is in agriculture on a seasonal basis, who has been so employed within the last 24 months, and who establishes, for the purposes of such employment, a temporary abode.

(ll) “Nutrition Aide” means an individual other than a nutritionist who is paid either in whole or in part by the local WIC Program and whose primary responsibility is the provision of paraprofessional nutrition services.

(mm) “Nutrition Education” means individual or group education sessions and the provision of information and educational materials designed to improve health status, achieve positive change in dietary habits, and emphasize relationships between nutrition and health, all in keeping with the individual’s personal, cultural, and socioeconomic preferences.

(nn) “Nutritional Risk” means:

(1) detrimental or abnormal nutritional conditions detectable by biochemical or anthropometric measurements;

(2) other documented nutritionally related medical conditions;

(3) dietary deficiencies that impair or endanger health; or

(4) conditions that predispose persons to inadequate nutritional patterns or nutritionally related medical conditions.

(oo) “Nutritionist” means an individual who is paid either in whole or in part by the local WIC Program and whose primary responsibility is the provision of nutrition services. This person shall hold a bachelor’s or master’s degree in clinical nutrition, community nutrition,

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dietetics, home economics with an emphasis in nutrition, nutritional sciences, or public health nutrition from a four year or post baccalaureate institution which is accredited by a recognized regional accrediting body.

(pp) “Outreach” means the systematic attempt to provide services to the entire WIC eligible community.

(qq) “Outreach Materials” means printed material, films, video tapes, audio tapes and other communications media which are used in the process of alerting the WIC eligible community to the service of the WIC Program.

(rr) “Participant” means pregnant women, breastfeeding women, postpartum women, infants and children who are receiving supplemental foods or food instruments under the WIC Program.

(ss) “Participant Abuse” means the participant’s knowing and deliberate misrepresentation to obtain WIC benefits; verbal or physical abuse or threat of physical abuse of local agency, department, clinic or vendor staff or property by a participant; the sale of supplemental foods or checks or their exchange for credit or purchase of unauthorized food or other items by a participant or other violations of state or federal law.

(tt) “Physician’s Assistant” means an individual who meets the requirements of Section 20-12a, as amended, of the General Statutes.

(uu) “Postpartum Women” means women up to six months after termination of pregnancy.

(vv) “Pregnant Women” means women determined to have one or more embryos or fetuses in utero.

(ww) “Priority System” means the basis for assigning degree of nutritional risk, as specified in the State WIC Manual, as amended.

(xx) “Priority Waiting List” means a list of potentially eligible individuals according to priority.

(yy) “Recognized Regional Accrediting Body” means one of the following regional accrediting bodies: New England Association of Schools and Colleges; Middle States Association of Colleges and Schools; North Central Association of Colleges and Schools; Northwest Association of Schools and Colleges; Southern Association of Colleges and Schools; and Western Association of Schools and Colleges.

(zz) “Regression” means the deterioration of nutritional status which may result from termination of WIC benefits, as determined by a CPA.

(aaa) “Service Area” means any office, room or space where the WIC Program operates. It includes all reception areas, waiting rooms, interviewing offices or locations, check distribution areas, and offices and other areas used for certification or nutrition education.

(bbb) “State WIC Manual” means the most recent standards established by the Commissioner for implementation of the Special Supplemental Nutrition Program for Women, Infants and Children, available from the department and hereby incorporated into the Regulations of State Agencies, Sections 19a-59c-1 through 19a-59c-6.

(ccc) “State WIC Program” means the Special Supplemental Nutrition Program for

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Women, Infants and Children which is administered by the Department of Public Health in accordance with the United States Department of Agriculture regulations, 7 CFR 246.1, through 246.28, as amended.

(ddd) “Suspension” means a temporary period during which a vendor or participant is prohibited from participation in the program for reasons of abuse or continued inability to meet program requirements, but is not disqualified.

(eee) “SWIS” means the Statewide WIC Information System which is a system of computer programs, manuals, and reports.

(fff) “Vendor” means any retail grocer, pharmacy, supermarket, or other food store.

(Effective March 2, 1993; Amended April 3, 1998)

Sec. 19a-59c-2. Eligibility criteria

To be eligible for State WIC Program benefits an individual shall:

- (a) reside in Connecticut, and
- (b) be recipients of Food Stamps or assistance under Temporary Assistance To Needy Families (TANF) or Medicaid, or be a member of a family that contains a TANF recipient or a pregnant woman or infant who receives Medicaid benefits, or have household income at or below 185% of the poverty income guidelines established by the Federal Office of Management and Budget, and
- (c) fit one of the following nutritional risk priorities:
 - (1) Priority I
 - (A) The presence of one or more of the following nutritional risk criteria shall qualify a pregnant or breastfeeding woman for Priority I:
 - (i) Anemia,
 - (ii) Past or present pregnancy induced hypertension,
 - (iii) Past or present gestational diabetes,
 - (iv) Severe nausea and vomiting,
 - (v) Nutrition related non-infectious chronic disease,
 - (vi) Recent or present nutrition related infectious disease,
 - (vii) Nutritionally significant genetic disease,
 - (viii) Clinical sign(s) of malnutrition,
 - (ix) Severe oral problems which impair ingestion of nutrients,
 - (x) Alcohol consumption,
 - (xi) Drug use,
 - (xii) Smoking,
 - (xiii) Other nutrition related medical condition(s),
 - (xiv) Underweight for height,
 - (xv) Overweight for height,
 - (xvi) Insufficient or excessive weight gain during pregnancy,
 - (xvii) Short interconceptional period,
 - (xviii) High parity,

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- (xix) Birth of a low birth weight infant,
- (xx) Birth of a premature infant,
- (xxi) Fetal or neonatal death or miscarriage,
- (xxii) Inadequate or excessive weight gain in recent pregnancy,
- (xxiii) Multiple pregnancy,
- (xxiv) Teenager or over 35 years of age at conception,
- (xxv) Breastfeeding woman whose infant is at nutritional risk, or
- (xxvi) Possible regression to a prior medical condition if removed from program.

(B) The presence of one or more of the following nutritional risk criteria shall qualify an infant for Priority I:

- (i) Anemia,
- (ii) Nutrition related non-infectious chronic disease,
- (iii) Recent or present nutrition related infectious disease,
- (iv) Nutritionally significant genetic disease,
- (v) Clinical sign(s) of malnutrition,
- (vi) Failure to thrive,
- (vii) Congenital defect with nutritional implications,
- (viii) Severe oral problems which impair the ingestion of nutrients,
- (ix) Other nutrition related medical conditions,
- (x) Low birth weight,
- (xi) Prematurity,
- (xii) Underweight or overweight for height,
- (xiii) Stunted growth,
- (xiv) Weight loss or deviation from normal pattern of growth,
- (xv) Infant of alcoholic or drug addicted mother,
- (xvi) Breastfeeding infant whose mother is at nutritional risk, or
- (xvii) Possible regression to a prior medical condition if removed from program.

(2) Priority II. Except those infants who qualify for Priority I, infants up to six months of age of program participants who participated during pregnancy, and infants up to six months of age born of women who were not Program participants during pregnancy but whose medical records document that they were at nutritional risk during pregnancy due to nutritional conditions detectable by biochemical or anthropometric measurements or other documented nutritionally related medical conditions which demonstrated the person's need for supplemental foods.

(3) Priority III. The presence of one or more of the following nutritional risk criteria shall qualify a child for Priority III:

- (A) Anemia,
- (B) Nutrition related non-infectious chronic disease,
- (C) Recent or present nutrition related infectious disease,
- (D) Nutritionally significant genetic disease,
- (E) Clinical sign(s) of malnutrition,

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- (F) Failure to thrive,
- (G) Congenital defect with nutritional implications,
- (H) Severe oral problems which impair the ingestion of nutrients,
- (I) Other nutrition related medical condition(s),
- (J) Underweight or overweight for height,
- (K) Stunted growth,
- (L) Weight loss or deviation from normal pattern of growth, or
- (M) Possible regression to a prior medical condition if removed from the program.
- (4) Priority IV.
 - (A) The presence of one or more of the following nutritional risk criteria shall qualify a pregnant or breastfeeding woman for Priority IV:
 - (i) Inadequate diet,
 - (ii) Pica,
 - (iii) Possible regression to a prior detrimental dietary condition if removed from the program,
 - (iv) Developmental disability, or
 - (v) Homeless individual or migrant.
 - (B) The presence of one or more of the following high risk criteria shall qualify a postpartum woman for Priority IV:
 - (i) Teenager,
 - (ii) Diagnosed chronic disease requiring a therapeutic diet, or
 - (iii) A poor obstetrical history.
 - (C) The presence of one or more of the following nutritional risk criteria shall qualify an infant for Priority IV:
 - (i) Inadequate diet,
 - (ii) Pica, possible regression to a prior detrimental dietary condition if removed from program,
 - (iii) Infant of a developmentally disabled woman, or
 - (iv) Homeless individual or migrant.
- (5) Priority V. The presence of one or more of the following nutritional risk criteria shall qualify a child for Priority V:
 - (A) Inadequate diet,
 - (B) Pica,
 - (C) Possible regression to a prior detrimental dietary condition if removed from program,
 - (D) Child of alcoholic or drug addicted mother,
 - (E) Child of a developmentally disabled woman, or
 - (F) Homeless individual or migrant.
- (6) Priority VI. The presence of one or more of the following nutritional risk criteria shall qualify a postpartum woman for Priority VI:
 - (A) Anemia,
 - (B) Recent or present pregnancy induced hypertension,

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- (C) Recent or present gestational diabetes,
- (D) Severe nausea and vomiting,
- (E) Nutrition related non-infectious chronic disease that does not require a special diet,
- (F) Recent or present nutrition related infectious disease,
- (G) Nutritionally significant genetic disease,
- (H) Clinical sign(s) of malnutrition,
- (I) Severe oral problems which impair the ingestion of nutrients,
- (J) Alcohol consumption,
- (K) Drug use,
- (L) Smoking,
- (M) Other nutrition related medical condition(s),
- (N) Prenatal or postnatal underweight for height,
- (O) Prenatal or postnatal overweight for height,
- (P) Insufficient weight gain during pregnancy,
- (Q) Excessive weight gain during pregnancy,
- (R) Short interconceptional period,
- (S) High parity,
- (T) Birth of a premature infant,
- (U) Fetal death or miscarriage,
- (V) Inadequate or excessive weight gain in recent pregnancy,
- (W) Multiple pregnancy,
- (X) Over 35 years of age at conception,
- (Y) Inadequate diet,
- (Z) Pica,
- (AA) Possible regression to a prior medical condition or a detrimental dietary condition if removed from the program,
- (BB) Developmental disability, or
- (CC) Homeless individual or migrant.

(Effective March 2, 1993; Amended April 3, 1998)

Sec. 19a-59c-3. Provision of WIC benefits

- (a) Supplemental foods must meet the requirements of:
 - (1) 7 CFR 246.10, as amended, and
 - (2) food package criteria in the State WIC Manual, as amended, and
 - (3) authorized food list as defined in subsection 19a-59c-1 (c) of Regulations of Connecticut State Agencies.
- (b) The department may withhold benefits from a priority group which is otherwise eligible to fund benefits for higher priority groups in accordance with 7 CFR 246.7 (g) (2), as amended.

(Effective March 2, 1993)

Sec. 19a-59c-4. Local WIC agency participation

(a) Local WIC agencies shall comply with federal regulations, state regulations and their contract with the State Program.

(b) General Administration

(1) Staffing

(A) Each local agency shall employ one full-time local agency coordinator who shall be responsible for its overall operation. This requirement may be waived by the Commissioner if the Commissioner determines that management obligations as set forth in this subsection may be met by employing a part-time coordinator. Such request for a waiver shall be in writing and give reasons why the Commissioner should grant the request for waiver. A coordinator hired before October 1, 1982 shall be deemed qualified under these regulations. A coordinator shall meet the following qualifications:

(i) a master's degree from an institution accredited by a recognized regional accrediting body in either public health, health administration, administration, business administration, or a health science; and

(ii) a bachelor's degree from an institution accredited by a recognized regional accrediting body; and

(iii) one year of full-time employment planning or administering a program, including supervising personnel, or

(iv) any combination of the above experience and training totaling six years. A bachelor's degree shall count for four years and a master's degree an additional one year. Nonsupervisory professional level experience in a WIC Program may be substituted for up to two years.

(B) Each local agency shall employ one full-time WIC program nutritionist who shall report to the program coordinator and be responsible for the nutrition services component of the program. A WIC program nutritionist hired before October 1, 1984 shall be deemed qualified under these regulations. A program nutritionist shall meet the following qualifications:

(i) a master's degree from an institution accredited by a recognized regional accrediting body in either nutritional sciences, community nutrition, clinical nutrition, dietetics, public health nutrition or home economics with a major in foods and nutrition, and one year of professional experience in nutrition in a health agency or health care facility, or

(ii) a bachelor's degree from a four-year institution accredited by a recognized regional accrediting body with a major in either foods and nutrition, community nutrition, nutrition education or nutritional sciences and 2 years of professional experience in nutrition in a health agency or health care facility.

A successfully completed internship or traineeship approved by the American Dietetic Association or a bachelor of science degree with a coordinated program or a master's degree in public health nutrition or a master's degree in nutrition education can qualify for one year of work experience. Persons with a master's degree in nutrition who do not have a bachelor's degree in foods and nutrition shall have successfully completed the equivalent

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subject matter at the graduate level to compensate for any courses not completed at the undergraduate level.

(C) Other WIC nutritionists who are hired by local agencies shall have a bachelor's degree from a four-year institution accredited by a recognized regional accrediting body with a major in foods and nutrition, community nutrition, nutrition education, or nutritional sciences.

(D) Nutrition aides who are hired by local agencies shall demonstrate to the satisfaction of the local agency WIC program coordinator:

(i) the ability to communicate clearly both orally and in writing in English, and in another language when the coordinator deems appropriate, and

(ii) the ability to establish rapport with individuals and small groups, or

(iii) successful completion of the department's paraprofessional training course.

(E) Each local agency shall maintain a WIC program staff which is sufficient to operate the program efficiently, effectively and economically. The Department shall presume that a local agency complies with this provision if it retains staff in accordance with the most recent revision of the State WIC Manual as promulgated from time to time by the Commissioner.

(F) Prior to appointment to fill a vacancy in a local agency, the state WIC program shall review and approve in writing the qualifications of selected candidates for the following positions:

(i) WIC coordinator,

(ii) WIC program nutritionist, and

(iii) WIC nutritionist.

(2) Temporary Appointments

(A) The local agency shall appoint an agency staff member to serve temporarily in an acting capacity as local WIC coordinator or program nutritionist if either position is vacated for four weeks or more. The local agency shall notify the state WIC program in writing of all such appointments expected to last four weeks or more. Individuals not meeting the qualifications for the permanent position may not serve in the acting capacity for more than two calendar months unless an extension is requested in writing by the local agency and approved in writing by the state WIC program.

(3) Caseload Management

(A) The state WIC program shall assign the number of people to be served by the local agency. The state WIC agency may adjust the caseload and direct the local agency to initiate a waiting list, deny WIC benefits to the lowest priority groups or terminate participants in mid-certification due to funding shortages.

(B) When the local agency's assigned caseload level is reached, the local agency shall continue to enroll any individual who meets the criteria for priorities I through VI unless notified otherwise in writing by the state WIC program.

(4) WIC Local Agency Plans

(A) Each local agency shall prepare, have on file, and implement a current program plan

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approved by the department which comprises all of the following sections:

- (i) background (including historical information and description of contracting agency);
- (ii) personnel and facilities (including job descriptions for all staff positions, addresses and days of WIC operations);
- (iii) program (including a needs assessment, goals and measurable objectives, action plans and methods of evaluation);
- (iv) systems and procedures for administration, certification, food delivery, outreach, and nutrition education;
- (v) lesson plans for nutrition education.

(B) The local agency shall revise their plan annually. Revisions shall include:

- (i) the section on program,
- (ii) modifications reflecting changes in the current status or operations of the local agency, and
- (iii) modifications requested by the state WIC program.

(5) Contracts for Nutritional Assessment. The local agency may contract with a competent professional authority to determine the nutritional risk status of potential WIC participants. The contract shall include, at a minimum, each of the provisions of the “model agreement for professional services to the WIC program” which is contained in the December 1997 State WIC manual and may be obtained by contacting the Connecticut Department of Public Health, WIC Program, 410 Capitol Avenue, M.S.11WIC, P.O. Box 340308, Hartford, CT 06134-0308 (Phone No: (860) 509-8084) and the following terms:

(A) How referrals and appointments shall be handled.

(B) If applicable, the amount of, and the manner in which payment shall be made for specified costs.

(6) Records

(A) Each local agency shall maintain complete records for:

- (i) outreach, as required in section 19a-59c-4(c), as amended;
- (ii) financial management, as required in subsection 19a-59c-4(d) of Regulations of Connecticut State Agencies, as amended;
- (iii) civil rights, as required in subsection 19a-59c-4(h) of Regulations of Connecticut State Agencies, as amended;
- (iv) certification, as required in subsection 19a-59c-4(i) of Connecticut State Agencies, as amended;
- (v) nutrition education, as required in subsection 19a-59c-4(i) and (k) of Connecticut State Agencies, as amended;
- (vi) food delivery, as required in subsection 19a-59c-4(l) of Connecticut State Agencies, as amended;
- (vii) food vendor participation, as required in subsection 19a-59c-5(a) and (b) of Connecticut State Agencies, as amended;
- (viii) final decisions on hearings involving participants; and
- (ix) records required by Federal Regulations including 7 CFR 246.25, as amended.

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(B) All local agencies shall obtain prior written approval from the state WIC program for the use of locally developed substitutes for the state forms.

(C) Records shall be retained by the local agency for a minimum of three years following the submission of the final expenditure report for the period to which the reports pertain. The state WIC office reserves the right to require longer retention for the resolution of an audit or any litigation.

(D) All records shall be available for inspection by authorized state WIC program, department and USDA representatives during normal business hours. Denial of access shall result in immediate disqualification.

(E) All records shall be destroyed in a manner which protects confidentiality. Private non-profit agencies shall submit a written request to destroy records stating which records and the manner in which they shall be destroyed to the State WIC office. Permission to destroy public records of municipal government agencies shall be obtained through the Connecticut State Library, Public Records Administrator. Permission, if granted, shall be in writing by a procedure adopted by that office pursuant to Sections 7-109 and 11-8 of the Connecticut General Statutes. Written notification of approval of the request to destroy records shall be maintained by the local agency for three years in accordance with 7 CFR 246.25, as amended. The state WIC program shall evaluate such requests based on compliance with records retention requirements in 7 CFR 246.25, as amended.

(7) Meetings

(A) Each local agency coordinator shall attend coordinators' meetings called by the state WIC program. In the event that the coordinator cannot attend a meeting, the local agency may send a representative.

(B) Each local WIC nutritionist shall attend the department's nutritionists' meetings called by the state WIC program.

(8) Continuing Education. WIC funds may be used for workshops and conferences, but may not be used for college or graduate school tuition or expenses.

(9) Office Hours. Local agency offices shall remain open continuously during regular business hours for five full working days a week, unless granted a waiver by the department upon written request to the state WIC program, because of inadequate staffing or other demonstrated inability to meet requirements of this subsection.

(10) Smoking Policy. Each local agency shall post a policy statement against smoking in any area where WIC program functions are performed, including check distribution sites where WIC services are provided on a part-time basis. These sites shall prohibit smoking during the times WIC is operating.

(11) Reporting. The local agency shall submit to the state WIC office the following reports as scheduled below:

(A) *Administration/Finance/Management*

Due Dates

(i) audit reports

Within 30 days of comple

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	tion of audit
(ii) budget submission	May 1
(iii) expenditure report	20th of month following report month
(iv) evaluation/performance report	December 1
(v) local agency plan	May 1
(vi) outreach	April 15 and October 15
(B) Nutrition	
(i) Nutrition Survey	May 1

(c) **Outreach**

(1) Publicity. Local agencies shall annually publicize, in a newspaper serving that program's area, the availability of WIC benefits including eligibility criteria and the location of local agency offices.

(2) Media Contacts are reports of any contact between the local agency and the media. The reports shall include all media event information in outreach reports submitted to the state WIC office.

(3) WIC Referrals

(A) Local agencies shall encourage referrals to WIC through the distribution of written information at least once per year to hospitals, private physicians, local clinics, community action agencies, social agencies, churches, neighborhood centers, welfare agencies, and other organizations in the service area who serve potential WIC eligibles.

(B) Local agency staff shall inform all WIC applicants and participants who may be eligible where they may apply for the TANF and Food Stamp Programs, the Medicaid Program, the Child Support Enforcement Program and the Expanded Food and Nutrition Education Program, if available.

(C) All referrals shall be documented.

(4) Outreach Materials. Local agencies shall use outreach materials which shall:

(A) be targeted to individuals at high risk,

(B) reflect ethnic and cultural groups in the community,

(C) be available in an appropriate foreign language when the local agency submits for determination by the state agency that the primary language of a substantial number of persons in the service area is not English,

(D) promote the WIC Program as a community nutrition program which operates as an adjunct to health care,

(E) contain the required nondiscrimination clause, as stated in 7 CFR 246.6, as amended.

(5) Records. The local agency shall submit a written report of outreach activities to the state WIC program biannually and include copies of all outreach materials used or planned for use which have not previously been submitted to the state WIC program. Such report shall include:

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- (A) date,
- (B) brief description of activity, including location,
- (C) staff involved,
- (D) population targeted, and
- (E) results/comments.

(d) **Financial Management**

(1) Accounting Records

(A) Each local agency shall maintain accurate and completely documented accounting records for all program funds received from the state WIC program. These records shall include:

- (i) budget, cash flow report (WIC 1-C),
- (ii) check stubs,
- (iii) infant formula register,
- (iv) monthly expenditure report WIC 1-B, and
- (v) equipment inventory.

(B) These records shall be made available by the local agency to state or federal personnel or agents acting in their behalf for periodic review or auditing purposes.

(2) Major areas. All local agency budget requests, expenditure records and reports shall classify all funds, under one of the following four areas:

(A) General Administration. All costs generally considered to be overhead or management costs, including:

- (i) salaries,
- (ii) fringe benefits,
- (iii) equipment,
- (iv) contracted services,
- (v) space rental,
- (vi) supplies,
- (vii) postage,
- (viii) telephone,
- (ix) printing and reproduction,
- (x) travel - in-state,
- (xi) travel - out-state, and

(xii) other outreach, maintain payroll, personnel, administrative, fiscal and program records, audit expenses, legal services.

(B) Client Services. All costs expended to deliver food and other client services and benefits, including:

- (i) salaries,
- (ii) fringe benefits,
- (iii) contract services,
- (iv) material preparation,
- (v) space rental,

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- (vi) application processing,
- (vii) medical supplies,
- (viii) travel-in-state and out state,
- (ix) notification of rights,
- (x) transfer of certification,
- (xi) planning of certification,
- (xii) telephone,
- (xiii) training,
- (xiv) conduct and participate in surveys/studies,
- (xv) transfer of certification,
- (xvi) income determination,
- (xvii) diet assessment,
- (xviii) equipment,
- (xix) anthropometric measurements,
- (xx) other assessments, and
- (xi) miscellaneous documentation.

(C) Nutrition Education. All costs directly related to general nutrition education, including:

- (i) salaries,
- (ii) fringe benefits,
- (iii) planning for nutrition education,
- (iv) travel - in or out of state,
- (v) material preparation,
- (vi) material procurement,
- (vii) equipment,
- (viii) printing,
- (ix) training staff,
- (x) counseling individuals,
- (xi) group education,
- (xii) continuing education,
- (xiii) data collection,
- (xiv) evaluation,
- (xv) monitoring,
- (xvi) telephone, and
- (xvii) space rental.

(D) Breastfeeding. All costs expended for promotion and support of breastfeeding, including:

- (i) salaries,
- (ii) fringe benefits,
- (iii) material preparation,
- (iv) material procurement,

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- (v) space rental,
- (vi) printing,
- (vii) contract services,
- (viii) counseling,
- (ix) training,
- (x) continuing education,
- (xi) breastfeeding promotion and support,
- (xii) telephone, and
- (xiii) travel - in or out of state.

(3) Line Items. Local agency budgets and expenditure records and reports shall classify funds under one of the twelve cost categories specified below:

(A) Salaries - costs of all salaries and wages.

(B) Fringe benefits - employees' contributions or expenses for social security, life and health insurance plans, unemployment compensation insurance coverage, workmen's compensation insurance, and pension plan.

(C) Equipment - purchase and rental of property having a useful life of more than one year and an acquisition cost of \$1,000.00 or more per unit.

(D) Contracted services. Chargeable under certification only. In cases where certification procedures are not performed by members of the local WIC staff, the local agency may contract with health care providers for such. Contracted services include only personnel compensation and laboratory fees.

(E) Space Rental. The total cost of space may not exceed the fair market rental cost of comparable space in the same locality. The cost of utilities, insurance, security, janitorial service, elevator service, grounds upkeep, normal repairs, and alterations are allowable to the extent they are not otherwise included in rental or other charges for space. Costs for rearrangement and alterations of facilities required specifically for the WIC program or those that increase the value or useful life of the facilities are allowable only when the state WIC program has given prior written approval.

(F) Supplies. Office supplies, books, publications, audio visual supplies, food demonstration supplies, and breastfeeding promotion aids.

(G) Postage.

(H) Telephone.

(I) Printing and reproduction. Total costs for printing and reproducing forms, reports, manuals, and informational literature.

(J) Travel Requirements. Records required by this paragraph shall be reviewed, approved and signed by personnel authorized by the local agency. The local agency shall retain a copy of the expense report. Travel records shall be maintained as follows:

(i) In-state. The local agency shall document:

- (a) date of trip,
- (b) driver's name,
- (c) beginning and ending odometer readings and total mileage,

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- (d) origin and destination of trip,
- (e) parking receipts and tolls,
- (f) reason for trip.
- (ii) Out-of-state. The local agency shall document:
 - (a) employee's name and position,
 - (b) reason for trip,
 - (c) date of trip,
 - (d) origin and destination,
 - (e) itemized costs as follows:
 - (1) date of each trip;
 - (2) employee's name;
 - (3) transportation tickets, hotel receipts, etc.;
 - (4) origin and destination of each trip;
 - (5) parking and taxi receipts; and
 - (6) reason for each trip.
- (K) Other. Continuing education, outreach, equipment maintenance, and other WIC program costs allowable under 7 CFR 246.14, as amended.
- (4) Special Limitations on Costs
 - (A) Nutrition education expenditures shall account for at least 25% of the total expenditures.
 - (B) All equipment purchases by the local agency over \$1,000.00 per item and equipment rental charges over \$50.00 per month are subject to approval, based on costs and necessity, in advance, by the state WIC Program. The local agency shall retain a copy of the request and approval.
 - (C) Space expenses. Costs for rearrangement and alterations of facilities required specifically for the WIC program or those that increase the value or useful life of the facilities are allowable only when the state WIC program has given prior written approval to the local agency. The local agency shall:
 - (i) submit to the state WIC program written requests with justification and detailed costs.
 - (ii) retain a copy of the request and the state response.
 - (D) Indirect costs. Indirect costs to local agencies are not allowed.
- (5) Annual Budgets
 - (A) Each local agency shall submit to the state WIC program by May 1 each year, an annual budget using state supplied budget forms.
 - (B) All budget line item modifications from the contract budget which bring the total of revisions to either \$500 for a line item or 10% of a line item, whichever is greater, are subject to advance, written approval by the state WIC program. Budget modifications of lesser amounts require written notification to the state WIC program. All budget modification requests shall be received by the state WIC program by September 30. The local agency shall submit requests in writing with justification and shall retain a copy of the request and the state response.

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(6) Reports

(A) Revenue, expenditures, and cash-on-hand shall be reported to the state WIC office monthly by the local agency.

(B) All revenue earned and expenditures which result in liabilities shall be reported by the local agency in the fiscal year for which they are contracted, even though the receipt of the revenue or the payment of the expenditure may take place in whole or in part in a previous or subsequent fiscal year.

(7) Settlement of Contract Account. Settlement of the contract account shall be made for each of the twelve line items as separate accounts. Differences shall be totaled to enable settlement with a single payment. Nutrition education expenditures shall account for at least 25% of the total expenditures.

(A) The local agency shall verify the state WIC program settlement figures and notify the state WIC program within 10 days of receipt of any discrepancies.

(B) The local agency shall refund excess advancement or request additional reimbursement within 30 days of the date of the settlement letter.

(e) Criteria for Selection of Local Agencies

(1) The department shall accept applications only from local agencies that meet the following criteria in priority order:

(A) a public or private nonprofit health agency that will provide ongoing, routine pediatric and obstetric care and administrative services.

(B) a public or private nonprofit health or human service agency that will enter into a written agreement with another agency for either ongoing, routine pediatric and obstetric care or administrative services.

(C) a public or private nonprofit health agency that will enter into a written agreement with private physicians, licensed by the state, in order to provide ongoing, routine pediatric and obstetric care to a specific category of participants (women, infants, or children).

(D) a public or private nonprofit human service agency that will enter into a written agreement with private physicians licensed by the state, to provide ongoing, routine pediatric and obstetric care.

(E) a public or private nonprofit health or human service agency that will provide ongoing, routine pediatric and obstetric care through referral to a health provider.

(2) The department shall consider applications to provide WIC program benefits to an area that has at least 600 potentially eligible individuals.

(f) Local Agency Disqualifications and Penalties

(1) A local agency shall be considered in violation of the WIC Program if it:

(A) fails to submit to the department, obtain approval for, or fully implement the local agency plan including the nutrition education portion;

(B) diverts money budgeted for administrative expenses to non-budgeted administrative items;

(C) fails to submit reports as required by the department;

(D) otherwise does not comply with the terms of its contract with the department.

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(2) When a local agency is found in violation of the state WIC program, it may be subject to one or more of the following penalties:

(A) reduction of reimbursement by 1/6 of the administrative budget for failure to fulfill its contractual responsibilities for nutrition education; reduction of reimbursement for costs of activities which were not authorized under the terms of the agreement with the state WIC program;

(B) termination of the agreement with the department; or

(3) A local agency may be disqualified from participation on sixty days advance written notice of the disqualification.

(g) **Dual Participation** - The potential dual application report shall be validated immediately upon receipt by the local agency. The local agency shall eliminate any real dual participation through its own or other local agencies.

(h) **Civil Rights**

(1) The local agency shall comply with all civil rights requirements as specified in 7 CFR 246.6, as amended. The nondiscrimination clause referred to in 7 CFR 246.6, as amended, shall appear on all materials that identify or describe the WIC program.

(2) **Discrimination Complaints**

(A) Within 24 hours the local agency shall send a copy of any complaint to:

- (i) Affirmative Action Officer, State of Connecticut, Department of Public Health; and
- (ii) State WIC Office, State of Connecticut, Department of Public Health.

(B) All complaints received by the local agency which allege discrimination based on race, color, national origin, sex, age or disability shall also be referred by the local agency to the Secretary of Agriculture, USDA, Washington, D.C. 20250.

(C) The local agency shall ensure that the identity of every complainant be kept confidential except to the extent necessary to carry out the purposes of this subsection, including the conduct of any investigation or hearing.

(D) **Records.** All records regarding any civil rights matter shall be retained a minimum of three years by the local agency.

(i) **Certification.** In accordance with the contract between the department and the local agency, the local agency shall cooperate in furnishing information in this subsection.

(1) The local agency shall develop a system to certify applicants for WIC benefits in accordance with the processing standards delineated in 7 CFR 246.7, as amended, and as specified in subdivisions 19a-59c-4(i) (1) through 19a-59c-4(i) (3) of the Regulations of Connecticut State Agencies. The processing standard begins when the applicant visits the local agency during office hours to request program benefits.

(2) Employed individuals seeking to apply for WIC benefits shall be given a convenient appointment so as to minimize the time that such an individual is absent from the workplace for the purpose of applying for the program.

(3) Pregnant women in priority I, infants, the homeless and migrants shall be notified by the local agency of their eligibility or ineligibility within 10 days of the date of the initial request for program benefits. An extension of the notification period to a maximum of 15

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days may be requested in writing by the local agency to the state agency.

(4) All other applicants shall be notified by the local agency of the determination of eligibility within 20 days of the date of the initial request for program benefits.

(5) Local program staff shall attempt to contact any pregnant woman who misses her initial certification appointment in order to reschedule the appointment.

(6) A CPA on the local agency staff shall certify as eligible all applicants who:

(A) reside in Connecticut, and

(B) meet the WIC approved categories, and

(C) meet the income standard, and

(D) are at nutritional risk, as defined in subsection 19a-59c-1(mm) of the regulations of Connecticut state agencies.

(7) Individuals who are being certified shall be physically present at the WIC office or satellite at the time of each certification. The local agency shall notify every applicant/participant prior to certification that the individual shall be present in order to complete the certification process. Physical presence shall be documented in the individual's certification file.

(8) Infants of women who were enrolled in the WIC program during pregnancy may be certified for up to six weeks of age without being physically present at the time of certification. Physical presence of the infant shall be documented by six weeks of age.

(9) When an applicant initially applies for WIC benefits, local agency staff shall determine if the applicant lives in Connecticut. State residency shall be verified by asking the applicant to present documentation which lists the applicant's name and address. Verification of residency is not required for homeless applicants.

(10) Nutritional risk shall be determined and documented by a CPA on the staff or on contract with the local agency.

(11) The CPA shall determine the extent of present health care and shall advise applicants and participants where they may go for adequate care.

(12) If the local agency does not have a contract with the CPA providing information on the nutritional status of a potential participant, then it shall be considered a referral and SHALL be reviewed by the local agency's CPA and countersigned.

(13) For determination of nutritional risk, the following data shall be obtained no more than 60 days before certification, provided that data used to determine the nutritional status of pregnant, postpartum or breastfeeding women was obtained while she was pregnant, postpartum or breastfeeding, respectively:

(A) height or length, and weight;

(B) a hematological test for anemia such as a hemoglobin or hematocrit test for all participants except for infants under six months of age and children whose blood values were normal at the previous certification. However, the test shall be performed on children whose values were normal at the previous certification at least once every 12 months.

(C) as a last resort, and after all other options have been pursued to resolve the issue of obtaining timely bloodwork data, as documented by the local agency on the participant

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certification form, a pregnant woman may be temporarily certified without bloodwork data, one time only during her pregnancy for a period which may not exceed 60 days, as long as she is otherwise eligible to receive program benefits.

(14) A diet history shall be performed by a nutritionist or by a staff person trained and supervised by the program nutritionist to assess the adequacy of the potential participant's diet. A diet assessment form shall be completed if the nutritional risk criterion for certification is based on a dietary inadequacy.

(15) The local agency shall ensure that at least two people are involved in the certification process for each participant. This shall be reflected on the certification form by having the CPA complete and sign the Medical/Nutritional assessment and another WIC staff member shall be responsible for the income eligibility determination.

(16) The local agency shall ensure that signatures on the WIC Certification Form are handwritten and shall comprise, at a minimum: first initial and last name. CPA signatures shall be legible.

(17) The local agency may extend the certification period for infants up to their first birthday, provided that the quality and accessibility of health care to infants are not diminished. A request for approval shall be made in writing to the state WIC program.

(18) The criteria for determining regression as defined in subsection 19a-59c-1(yy) of Regulations of Connecticut State Agencies shall not be used for an initial certification or for the recertification of priority II infants or postpartum women. These criteria may be used only if there was a documented nutritional risk condition at a prior certification, as evidenced by anthropometric, biochemical, clinical or dietary assessment. The regression criterion may not be used two or more times consecutively to certify an individual.

(19) Priority Assignment

(A) Participants certified on the basis of regression shall be assigned to the same priority group to which they were previously assigned.

(B) High risk postpartum women shall be assigned to priority IV. (See the State WIC Manual).

(C) Both the mother and infant of a breastfeeding dyad shall be assigned the highest priority for which either qualifies.

(D) A participant shall be assigned to the highest priority group for which he or she is eligible.

(20) Transfer of Certification

(A) The local agency shall comply with all requirements related to transfer of certification as specified in 7 CFR 246.7 (j), as amended, and in subparagraph 19a-59c-4 (i) 16 (B) through (D) of Regulations of Connecticut State Agencies.

(B) The local agency shall accept all verification of certification (VOC) cards which are recognized as state or national cards if such cards include as a minimum the participant's name and the certification date, including those cards which may have some incorrect information. A person with a valid VOC card shall not be denied participation because the person does not meet the state WIC program's eligibility criteria.

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(C) If the certification period is still valid and the VOC card is incomplete, the local agency shall obtain the missing information and complete the card.

(D) If the certification period is no longer valid, the local agency shall process the individual as a new applicant.

(21) Certification Records - The local agency shall maintain complete certification records for active WIC participants composed of:

(A) request for alternate/proxy (WIC-12);

(B) certification form(s);

(C) prenatal weight gain grid for women, growth charts for children;

(D) nutrition education documentation;

(E) diet assessment form(s) in accordance with subsection 19a-59c-4(h) of Connecticut State Agencies, as amended;

(F) high risk care plan in accordance with subsection 19a-59c-4(j) of Connecticut State Agencies, as amended; and

(G) denial form for the National Voter Registration Act, if warranted.

(22) Aliens. During the certification process if it becomes known that the applicant is an alien, the local agency shall:

(A) inform aliens that participation in WIC may be considered by the Immigration and Naturalization Service (INS) as an indication that they have become a public charge and may be subject to deportation in accordance with the Immigration and Nationality Act (8 U.S.C. 1251 (a) (8)).

(B) refer the applicant to the INS for counseling,

(C) not further advise the applicant on this subject,

(D) refer any INS officials seeking information regarding WIC program participation to the state WIC office.

(23) Phenylketonuria (PKU). The certification and enrollment in the WIC program of eligible children who have PKU shall be accomplished through coordinated efforts of the local agency, the PKU clinics, the state WIC and genetics programs and the primary care providers.

(A) The local agency shall complete the initial and subsequent certification.

(B) The local agency shall establish and maintain certification records for all WIC/PKU participants.

(C) The local agency shall issue an appropriate PKU formula to infants and children when prescribed by a physician and not provided by another source.

(D) Other inborn errors of metabolism shall be handled in the same manner as PKU.

(24) Termination. A termination notice shall be provided to participants, in writing, no less than 15 days before the disqualification. The notice should include reasons for disqualification and the right to a hearing under Chapter 54 of the general statutes and section 19a-2A-1 through 19a-2A-41 of Connecticut State Agencies, as amended, of regulations of Connecticut State Agencies. The local agency shall terminate a WIC participant:

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(A) if there are individuals waiting who, according to the priority system, are at greater nutritional risk;

(B) who is no longer in a WIC approved category;

(C) whose family income exceeds the income guidelines;

(D) if participant requests termination;

(E) for participation in more than one local WIC program;

(F) who abuses the program as specified in subsection 19a-59c-6 (a) of Regulations of Connecticut State Agencies; or

(G) if directed by the state agency for administrative or fiscal reasons.

(25) Waiting Lists. As directed by the state WIC program, the local agency shall maintain a waiting list of individuals who visit the local agency to express an interest in receiving program benefits and who are likely to be served. However, in no case shall an applicant who requests placement on the waiting list be denied inclusion on the list.

(A) The competent professional authority shall fill vacancies, as directed by the state WIC program, by applying the participant priority system as defined in subsection 19a-59c-1(vv) of Regulations of Connecticut State Agencies and 7 CFR 246.7(d) (4), as amended.

(B) The waiting list shall comprise the following:

(i) name, address, telephone number;

(ii) categorical status; and

(iii) date placed on the waiting list.

(j) Local agency staff shall conduct an orientation for each participant to include:

(1) the general purpose and scope of WIC,

(2) the food delivery system,

(3) encouragement to attend all nutrition education activities,

(4) the importance of obtaining health care,

(5) rights and responsibilities as specified on the certification form, and

(6) The option of registering to vote.

(k) **Nutrition Services**

(1) The nutrition services component of the local agency shall be the primary responsibility of the WIC program nutritionist.

(2) A competent professional authority at the local agency shall prescribe or modify the food package for each participant according to federal requirements that delineate the quantity and quality of food to be prescribed to participants as specified in the State WIC Plan, as currently revised.

(3) **Nutrition Education**

(A) The local agency shall make nutrition education available to each participant at least twice every six months through individual or group sessions which are appropriate to the individual participant's nutritional needs and based upon the U.S. Dietary Guidelines (U.S. Department of Agriculture and U.S. Department of Health and Human Services, Home and Garden Bulletin No. 232). All pregnant participants shall be encouraged to breastfeed unless contraindicated for health reasons as determined by a physician.

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(B) The local agency shall offer newly enrolled participants an explanation of one or more of the following:

- (i) participant's nutritional risk condition and ways to achieve an adequate diet;
- (ii) either verbally or through an audio-visual presentation, the type and amount of food approved by the program;
- (iii) the importance of the supplemental foods being consumed by the participant for whom they are prescribed rather than by the whole family;
- (iv) that the program is a supplemental rather than a total food program;
- (v) the nutritional value of the supplemental food; or
- (vi) the importance of health care.

(C) The local agency shall offer subsequent nutrition education contacts as described in the local agency plan, to include a discussion of the following:

- (i) participants' particular nutritional needs according to the category of eligibility, i.e., needs of pregnant, breastfeeding, postpartum women, infants, and children;
- (ii) relationship of diet to health;
- (iii) the benefits of consuming a variety of foods including those not provided by the program;
- (iv) nutrients of special interest or need to the participant; and
- (v) additional topics at the local agencies discretion, as described in the local agency plan.

(D) The local agency shall implement a plan to promote breastfeeding among participants.

(E) The local agency shall provide information on the dangers of drug, alcohol and tobacco use during pregnancy to each pregnant participant, and appropriate referrals shall be made.

(F) The local agency shall document nutrition education as follows:

- (i) topic(s),
- (ii) date,
- (iii) staff initials, and
- (iv) participant refusal or inability to attend or participate.

(G) Each local agency shall use other available community resources, such as the Expanded Food and Nutrition Education Program (EFNEP), in providing nutrition education.

(H) The local agency nutritionist shall develop and implement a nutrition care plan for each high risk participant and any other participant who wishes to have such a plan.

(I) Food Delivery

(1) The local agency shall issue checks which correspond to the food packages selected by the CPA, according to the procedures and policies as prescribed by SWIS.

(2) The local agency staff shall issue a WIC identification (ID) card or folder to each participant.

(3) Alternate (Proxy) Authorization. A participant may request in writing authorization

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of an alternate to pick up or redeem WIC checks. In cases which the local coordinator or CPA determines to be hardship, a one month alternate may be authorized without a written request from the participant. The justification for authorization of an alternate and a copy of the alternate's name and signature shall be obtained by the local agency prior to authorization. The process of authorizing alternates shall ensure that only two individuals - the participant and the current alternate - may use the WIC checks. The local agency shall clearly document the individual(s) authorized to use each set of WIC checks and these individuals' signatures shall be on file at the local agency.

(4) The local agency shall prorate participants' food packages as prescribed by SWIS.

(m) Managment Information Systems

(1) The local agency shall follow security policies with regard to copyright laws, equipment, backup and recovery, installation and upgrades and software passwords as established by the state WIC office.

(Effective March 2, 1993; Amended April 3, 1998)

Sec. 19a-59c-5. Food vendor participation

(a) In order to be considered for authorization, a vendor shall:

(1) be necessary to the program as determined in accordance with subsection 19a-59c-5(c) of Regulations of Connecticut State Agencies and as specified in the WIC vendor agreement.

(2) request an application package in writing,

(3) submit a completed application package by the due date, and

(4) meet the minimum criteria at the time of an authorized site visit as established by the state WIC program in subsection 19a-59c-5(c) of Regulations of Connecticut State Agencies and according to 7 CFR 246.12, as amended.

(b) The state WIC program, in cooperation with local agencies, shall process requests from food vendors who wish to become authorized WIC vendors, monitor vendor performance, document and resolve participant complaints.

(1) When the local agency is contacted by a vendor requesting authorization, the following procedure shall be followed:

(A) During the open enrollment period, which is designated by the state WIC program, the local agency will direct the vendor to submit the request in writing to the state WIC office.

(B) Applications will not be accepted any time other than the open enrollment period and before the due date. However, the state WIC program may authorize vendors based upon documented participant hardship at times other than open enrollment. In case of participant hardship, the local agency shall refer the vendor to the state WIC office.

(2) For vendors in its area, the local agency shall maintain a file which contains the following information:

(A) data sheet including store name, address, WIC vendor number and contact name;

(B) changes in vendor; e.g., change of ownership or address;

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(C) documentation of any telephone conversations with the vendor and complaints received about the vendor;

(D) any other information which the department deems pertinent.

(3) The local agency shall process participant complaints as follows:

(A) document receipt of the complaint in writing to include:

(i) date of complaint,

(ii) name of participant making complaint (if available),

(iii) name of vendor about whom participant is making complaint, and

(iv) nature of complaint according to participant.

(B) submit the original of the written documentation to the state WIC program within 5 working days;

(C) retain a copy of the written documentation for the local agency file.

(c) Authorization of WIC vendors is the sole responsibility of the state WIC program. Vendor agreements are between the state and the vendor. The department shall authorize an appropriate number and distribution of food vendors, as well as perform an effective review and monitoring of vendors. The appropriate number and distribution of vendors shall be based upon store location, number of authorized stores in the area, the number of WIC participants in that area, adequate participant access and lowest prices charged by vendor. The department may make any adjustments in the number of authorized stores required for special needs such as second language stores and access for the handicapped.

A vendor shall not be authorized by the state WIC program if the minimum requirements of the program are not met at the time of an initial visit. Minimum requirements include posting product prices, stocking the minimum inventory, attending vendor training sessions, maintaining WIC redemptions of an average of twenty-five checks per month, store business hours a minimum of 10 hours a day, 6 days a week and no history of overcharging the WIC Program. Satisfactory Food Stamp compliance as evidenced in part by no Food Stamp charge letter on file. Prices charged by stores for WIC foods cannot exceed fair market prices as determined by the state WIC program.

After the initial pre-authorization visit, inventory audits shall be conducted and periodic visits shall be made to authorized vendors. On-site monitoring and compliance investigations shall be performed by department staff or contracted designees.

These inventory audits and additional visits, made during the period of authorization, may result in warning, fine, or disqualification letters being issued, dependent on the abuse. On any visit made to a store, the minimum requirements shall be met at the time of the visit or the vendor may be subject to penalties in accordance with subsection 19a-59c-6(c) of Regulations of Connecticut State Agencies, as amended. Details of any violations shall be documented.

(d) Vendor Agreements are rendered null and void if the ownership changes. The food vendor shall notify the state WIC program when the vendor ceases operation or when the ownership changes.

(Effective March 2, 1993; Amended April 3, 1998)

Sec. 19a-59c-6. Program abuse

(a) Participant Abuse

(1) In cases of participant abuse of the WIC program, the local agency shall:

(A) issue all warnings either in writing or orally to the participant in the presence of at least one witness, and document the abuse in the participant's file by recording name, date, description of incident and name(s) of witness(es);

(B) if a decision is made to suspend the participant, hand deliver or mail, by certified mail, return receipt requested, a written notice of suspension indicating length of time and reason;

(C) mail a copy of the notice of suspension to the state WIC office within 15 days, and retain copies in the participant's file;

(D) should the participant request a hearing, have the participant complete the necessary hearing form, and forward it to the state WIC office;

(E) report threats or acts of violence against a person or property immediately to the police;

(F) if the abuse in question includes the sale of supplemental foods or checks or their exchange for credit toward the purchase of unauthorized food or other items by the participant,

(i) report by phone alleged or suspected abuse to the State WIC Office immediately, provide written documentation within 15 days, retain a copy in the participant's file, include name, date, description of the incident, names of witnesses, and other appropriate information, and

(ii) implement actions regarding the participant's WIC status as described in subparagraph 19a-59c-6(a) (1) (B) of Regulations of Connecticut State Agencies, as amended, unless given other instructions by the state WIC office, and maintain documentation of actions taken;

(iii) Claims Against Participants - The recovery of the cash value of program benefits which have been improperly issued to a participant due to the intentional misrepresentation or withholding of information may be initiated by the state agency in addition to imposition of the sanctions described in subsection 19a-59c-6(a) of Regulations of Connecticut State Agencies, as amended. The state agency may pursue recovery when the value of the overissuance exceeds \$300.00.

(G) inform participant of the right to review termination, disqualification, or suspension from the WIC program in accordance with section 19-2a-1 through 19-2a-40, as amended, of Regulations of Connecticut State Agencies.

(2) Category I Violations

(A) Category I violations are actions related to misuse of checks, including but not limited to:

(i) refusal to follow proper redemption procedures such as signing checks,

(ii) failure to follow proxy procedures,

(iii) selection of unauthorized foods within an approved food category, or

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(iv) selection of unauthorized quantities of authorized foods.

(B) Category I violations shall be subject to the following sanctions:

- (i) a written or oral warning for the first occurrence within a 12-month period,
- (ii) a one month suspension for the second occurrence within a 12-month period, and
- (iii) a three month suspension for the third violation within a 12-month period.

(3) Category II Violations

(A) Category II violations are actions related to misuse of program benefits and participant rights, including but not limited to:

- (i) verbal abuse of program, local agency or vendor staff,
- (ii) redeeming checks which have expired or been altered, and
- (iii) purchase of unauthorized foods, or returning WIC foods for cash.

(B) Category II violations shall be subject to the following sanctions:

- (i) a written or oral warning for the first actual or attempted occurrence, and
- (ii) a three month suspension for any subsequent, actual or attempted occurrence within a 12-month period.

(4) Category III Violations

(A) Category III violations are actions related to deliberate fraud or abuse of the WIC program, including but not limited to:

- (i) physical abuse of program, local agency or vendor staff;
- (ii) misrepresentation of eligibility for program benefits;
- (iii) purchase of non-food items;
- (iv) purchase of alcohol or tobacco products;
- (v) exchanging checks for cash;
- (vi) sale of WIC foods;
- (vii) receipt from food vendors of cash or credit toward purchase of unauthorized foods or other items of value in exchange for checks; or
- (viii) simultaneous participation in more than one local agency WIC program.

(B) Category III violations shall be subject to a three month suspension for any offense.

(b) **Applicant Abuse** - Sanctions shall be applied by the local agency when an applicant knowingly and deliberately misrepresents circumstances to obtain WIC benefits, or, when an applicant uses verbal or physical abuse or threat of physical abuse to local agency, clinic or vendor staff or property, or refuses to cooperate when asked for information.

(1) Penalty - Denial of participation in the WIC program.

(2) The local agency shall:

(A) issue a written Denial of Participation Notice stating the reason for the denial and the right to a hearing;

(B) mail a copy of the Denial of Participation Notice to the state WIC office within 15 days, which shall include a notice of the right of review, and retain copies in the participant's file;

(C) should the applicant request a hearing, have the applicant complete the necessary hearing form and forward to the state WIC office; and

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(D) report threats or acts of violence against a person or property immediately to the police.

(c) **Vendor Abuse** - Sanctions are to be applied by the state WIC program against vendors based on the nature and severity of violations and the Vendor authorization agreement. Depending upon the offense, the state WIC program may impose the following:

(1) Warnings - A warning letter shall be sent to the vendor upon documentation of the first violation for abuses in accordance with the WIC vendor agreement for certain abuses.

(2) Fines and disqualifications - civil penalties—a civil penalty pursuant to Section 19a-59d of the General Statutes may be imposed on vendors in lieu of or in addition to disqualification. Disqualification may result upon documentation of certain abuses by a vendor in accordance with the following:

(A) **Class A violations:** An automatic three-year disqualification shall be assessed for the following violations:

- (i) providing cash for redemption of a WIC check,
- (ii) allowing cigarettes or alcoholic beverages to be purchased with a WIC check,
- (iii) allowing any non-food items such as soaps, paper goods, etc. to be purchased with a WIC check,
- (iv) not providing refunds or not paying fines by the due date as requested by the WIC program,
- (v) using a counterfeit WIC vendor stamp,
- (vi) receiving, transacting, or redeeming WIC checks outside of authorized channels or through unauthorized persons,
- (vii) forging the signature of a WIC participant/alternate or a designee of the WIC program on any WIC document,
- (viii) charging the WIC program for foods not received in exchange for a WIC check as determined during compliance purchases or check audits, or
- (ix) charging the WIC program more for WIC foods than the lesser of the shelf or sale price at the time of purchase as determined during compliance purchases or check audits.

(B) **Class B violations:** A six-month disqualification or a five hundred dollar (\$500.00) fine in lieu of disqualification shall be assessed for each occurrence of the following violations. Upon the fifth Class B violation within a one-year period, a two-year disqualification shall be imposed. The option to pay a fine shall not be available at that time:

- (i) the inability to justify WIC redemptions through documented WIC food item purchases,
- (ii) pricing a WIC check by type rather than by the actual purchase price of the foods,
- (iii) not providing information as requested by the WIC program within the time frame that is stated,
- (iv) not having the participant enter the purchase price in ink on a WIC check at the time of the purchase, or
- (v) redeeming a WIC check for any food not specified on the WIC check or WIC food list.

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(C) **Class C violations:** A three-month disqualification or a two hundred fifty dollar (\$250.00) fine in lieu of disqualification shall be assessed for each occurrence of the following violations. Upon the fifth Class C violation within a one-year period, a one-year disqualification shall be imposed. The option to pay a fine shall not be available at that time:

- (i) accepting a WIC check before the approved WIC foods have been provided or for credit, iou's or rain checks,
- (ii) redeeming an altered WIC check,
- (iii) not attending assigned training sessions,
- (iv) allowing the return of any WIC purchases, or
- (v) providing false information on any WIC document or on any WIC request for information.

(D) **Class D violations:** A one hundred twenty-five dollar (\$125.00) fine shall be assessed for each occurrence of the following violations. Upon the Fifth Class D violation within a one-year period, a six-month disqualification shall be imposed. The option to pay a fine shall not be available at that time:

- (i) not checking the WIC program identification card or folder at the time of purchase,
- (ii) not verifying the WIC participant/alternate signature at the time of purchase,
- (iii) not posting all WIC food prices on the item itself or on the shelf or door in front of the item,
- (iv) not having the minimum inventory of WIC-approved foods on shelves at all times,
- (v) not providing savings to WIC participants/alternates through the use of coupons or store offered promotions that include WIC authorized foods, or
- (vi) accepting a WIC check before the "first day to use" or after the "last day to use" as specified on WIC checks.

(E) FNS Programs- whenever a vendor is disqualified from participation in any other FNS (Food and Nutrition Service) program such as the Food Stamp Program, the vendor shall also be disqualified from participation in the WIC program for the same length of time up to a maximum of three (3) years. Also, if a vendor is assessed a civil money penalty in lieu of disqualification from a FNS program, that vendor shall be disqualified from the WIC program for the same length of time that the FNS program would have disqualified the vendor up to a maximum of three (3) years. In addition, if a vendor is assessed a settlement fine, or any other monetary penalty or fee relating to a disqualification from the Food Stamp Program, a WIC civil penalty shall be assessed the vendor equal to the lesser of the FNS penalty or two thousand five hundred dollars (\$2500.00).

(F) Intent to pay- if the option to pay a fine in lieu of disqualification for Class B or Class C violations is elected, the total amount of the fine is payable on or before the date the disqualification would have been effective. The notification of intent to pay the fine shall be received at the department of Public Health within seven (7) days of receipt of the WIC program sanction letter. Any fines levied for Class D violations are payable fifteen (15) days from receipt of the WIC program sanction letter.

(G) Undue hardship - if the WIC program determines that there shall be undue hardship

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for WIC participants if a vendor is disqualified, the store shall be allowed to remain on the program until such time that undue hardship no longer exists. A fine of two thousand five hundred dollars (\$2500.00) shall be paid by the vendor to continue to accept WIC checks. A hearing may be requested to determine if the disqualification is warranted. At such time that the WIC program determines that undue hardship no longer exists, the vendor shall be notified that the original disqualification shall be effective fifteen (15) days from receipt of the letter. The vendor may request a hearing for the sole purpose of arguing the issue of undue hardship.

(H) Aggregate fines - any store that has paid more than two thousand five hundred dollars (\$2500.00) in fines in the last three (3) years shall not be selected for authorization.

(3) Expiration - records of violations shall be erased after related disqualification periods have been served. However, warnings shall remain active during the entire term of the store's current ownership.

(4) Termination. The right to terminate the Agreement may be exercised by either party upon not less than fifteen (15) days advance written notice. Neither the State of Connecticut, Department of Public Health nor the vendor has any obligation to renew the Vendor Agreement.

(5) Waiver of Sanctions - The state WIC program may waive the action against the vendor if such action would significantly impair the ability of the state WIC program to meet its goals and objectives.

(6) Notice of review: Any person aggrieved by an order issued by the state WIC program may request a review of the order by the commissioner. Expiration of the agreement is not subject to review. The request for review shall be received by the commissioner within seven (7) days of the date of issuance of the order. If the seven (7) day period expires on a day which is not a normal business day for the department, the time period for making a request for review shall be extended through the close of business of the first regular business day following.

The request for review shall state:

- (A) the name of the person claiming to be aggrieved;
- (B) the nature of the claimed aggrievement;
- (C) the order being reviewed; and
- (D) the grounds for review.

(Effective March 2, 1993; Amended April 3, 1998)

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Agency

Department of Health Services

Subject

Connecticut Tumor Registry

Inclusive Sections

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Connecticut Tumor Registry

Sec. 19a-73-1. Tumor registry regulations. Connection of information on occupational history

All short term and long term hospitals licensed under sections 19a-490 to 19a-503, inclusive, of the Connecticut General Statutes shall collect information on occupational history from each newly diagnosed cancer patient.

(Effective September 23, 1983)

Sec. 19a-73-2. Content of history

Occupational history shall include places of employment, types of employment and length of employment of the cancer patient prior to diagnosis of cancer.

(Effective September 23, 1983)

Sec. 19a-73-3. Recording of history on form

The occupational history shall be recorded on a form to be provided by the State Department of Health Services, and shall be filed in the medical record of the patient.

(Effective September 23, 1983)

Sec. 19a-73-4. Availability of forms

A copy of the occupational history forms shall be made available to the hospital tumor registrar or other hospital employee who is responsible for reporting information on newly diagnosed cancer cases to the tumor registry in the Department of Health Services.

(Effective September 23, 1983)

Sec. 19a-73-5. Registration of forms

The hospital tumor registrar or other designated hospital employee shall submit a copy of the occupational history form to the tumor registry in the Department of Health Services at the time the regular cancer report forms are submitted as required by section 19a-73-6 of these regulations.

(Effective September 23, 1983)

Sec. 19a-73-6. Reporting

Each general, special and chronic disease hospital licensed under chapter 368v of the Connecticut General Statutes and each clinical laboratory licensed under section 19a-30 of the Connecticut General Statutes shall report within six months of the close of the calendar year, on forms furnished by the State Department of Health Services, such information as the department requires concerning diagnosis, stage of disease, medical history, laboratory data, tissue diagnosis, radiation, surgical or other methods of treatment, and annual lifetime follow-up on each cancer patient at such times as are necessary to maintain the Connecticut

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Tumor Registry.

(Effective September 23, 1983)

Sec. 19a-73-7. Non-compliance

Failure to comply with the requirements stated in section 19a-73-6 above within six months after the end of a calendar year may be a cause for suspension or revocation of the license of the hospital or clinical laboratory.

(Effective September 23, 1983)

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§

Public Sources of Nicotine Yield Ratings for Cigarettes

Sec. 19a-74a-1. Definitions (Repealed)

Repealed June 11, 2014.

(Adopted effective September 13, 2001; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-74a-2. Access to information (Repealed)

Repealed June 11, 2014.

(Adopted effective September 13, 2001; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

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Subject

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Per Capita Grants for Part-Time Health Departments

Sec. 19a-76-1. Definitions

(1) “Full-time local director of health” or “director” means a municipal or district director of health who is responsible for enforcing public health laws and administering public health programs; and is employed on a full-time basis by a district or municipality.

(2) “Part-time health department” means a health department that has been designated by a municipality as a part-time health department for purposes of section 19a-202a of the Connecticut General Statutes.

(3) “Health department” means the municipality or district unit which is administered by the full-time local director of health.

(4) “Commissioner” means the Commissioner of Public Health.

(5) “Employee” means a person who: (1) is designated as a local director of health pursuant to section 19a-200 of the Connecticut General Statutes; or (2) reports to a local director of health, and is licensed pursuant to the provisions of chapters 370, 371, 379, 395, subsections (a) or (b) of section 20-87a of the Connecticut General Statutes or holds a bachelor’s or higher degree in public health from a regionally accredited college or university; and (3) is employed by a part-time health department to provide services pursuant to section 19a-76-2 of the Regulations of Connecticut State Agencies.

(6) “Full-time employee or its equivalent” means a maximum of three employees, as defined in subdivision (5) of this section, whose total work week consists of a minimum of thirty-five hours.

(Effective December 15, 1983; Amended April 29, 1999)

Sec. 19a-76-2. Basic local health program

(a) Except as provided in subsection (c) of this section, to be eligible for state grants under section 19a-202 or section 19a-245 of the Connecticut General Statutes or section 19a-202a of the Connecticut General Statutes health departments shall ensure the provision of a basic public health program in accordance with subsection (b) below. The health department may ensure the provision of a program by directly providing the service, contracting with another health department or community agency or coordinating public health services with other community or regional resources providing specialized services. Nothing in these regulations shall prohibit any health department from providing health services in addition to the basic services described in subsection (b) below.

(b) The basic health program to be provided shall include the following services that prevent disease or reduce conditions that have an adverse effect on health:

(1) Public health statistics. There shall be participation in a mechanism for the collection, tabulation, analysis and reporting of public health statistics for the health jurisdiction served;

(2) Health education. There shall be public and professional information and education with emphasis on prevention and individual responsibility for health status, community organization and outreach;

(3) Nutritional services. There shall be a nutrition program including appropriate

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activities in education and consultation for the promotion of positive health, the prevention of ill health, and the dietary control of disease;

(4) Maternal and child health. There shall be a comprehensive plan for maternal and child health services to include but not necessarily be limited to:

- (A) Prenatal, childbearing, and reproductive care;
- (B) Family planning;
- (C) Child and adolescent health including school health;
- (D) Child abuse;
- (E) Genetic disease control;
- (5) Communicable and chronic disease control

(A) There shall be preventive services including immunization, screening, consultation, diagnostic services, epidemiological investigation, and community education;

(B) The qualifying health department shall identify resources and provide referral for treatment and rehabilitation of persons with communicable, chronic, and handicapping conditions including, but not necessarily limited to, tuberculosis, venereal disease, cancer, hypertension, and cardiovascular disease;

(C) There shall be a plan for the prevention and control of vision, hearing, and dental problems;

(6) Environmental services. These shall include activities relating to water, food, air, wastes, vectors, housing, bathing places, safety, noise, toxic hazards, and nuisances in the community and work place;

(7) Community nursing services. There shall be provision for community nursing need to implement programs for which the qualifying health department is responsible;

(8) Emergency medical services. There shall be provision for the development and implementation of an emergency medical service system to include: identification of primary services, written mutual aid and mass casualty plans, and participation in regional planning.

(c) A municipality that has designated itself as having a part-time health department may ensure the provision of a basic public health program as described in subsection (b) of this section by directly providing the service, contracting with another health department or community agency or coordinating public health services with other community or regional resources providing specialized services.

(Effective December 15, 1983; Amended April 29, 1999)

Sec. 19a-76-3. Use of funds

(a) Funds available to qualifying health departments under section 19a-202 or section 19a-245 of the General Statutes shall be used only to augment local appropriations provided for public health purposes through the health department in furtherance of those functions listed in section 19a-76-2 of these regulations and any other programs approved by the commissioner.

(b) Funds available to qualifying health departments under section 19a-202a of the

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Connecticut General Statutes shall be used only for public health purposes through the health department in furtherance of those functions listed in section 19a-76-2 of the Regulations of Connecticut State Agencies and any other programs approved by the commissioner.

(Effective December 15, 1983; Amended April 29, 1999)

Sec. 19a-76-4. Applications for funds

(a) Budget and program

(1) The director of each health department applying for funds under section 19a-202 or section 19a-245 of the Connecticut General Statutes or section 19a-202a of the Connecticut General Statutes shall submit a budget each year showing a total plan for the expenditure of all public health funds during the year together with an outline of the programs contemplated.

(2) Budget and program revisions shall be approved by the commissioner prior to implementation.

(b) Reports

(1) At the end of each fiscal year, the director of each qualifying health department shall submit to the commissioner reports of expenditures, operations, and services provided.

(Effective December 15, 1983; Amended April 29, 1999)

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Subject

Child Day Care Centers & Group Day Care Homes

Inclusive Sections

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Child Day Care Centers & Group Day Care Homes

Sec. 19a-79-1—19a-79-8. Repealed

Repealed July 27, 1993.

Sec. 19a-79-1a. Definitions

- (1) “Administration of medication” means the direct application of a medication by inhalation, ingestion or any other means to the body of a person;
- (2) “Advanced practice registered nurse” means an individual licensed pursuant to subsection (b) of section 20-94a of the Connecticut General Statutes;
- (3) “Alteration” means remodeling or revision that does not change the physical plant of the licensed space;
- (4) “Alternate staff” means a substitute;
- (5) “Ambient air” means the surrounding air;
- (6) “Attendance” means the names and number of children and staff present at the facility on a daily basis;
- (7) “Authorized prescriber” means a physician, dentist, advanced practice registered nurse or physician assistant;
- (8) “Business day” means the normal and customary workday schedule;
- (9) “Certified playground safety inspector” means an individual certified by the National Playground Safety Institute, a program of the National Recreation and Park Association;
- (10) “Child day care center” means a program of supplementary care for more than twelve (12) related or unrelated children outside their own homes on a regular basis;
- (11) “Child or children with special health care needs” means a child or children who have or are at risk for chronic physical, developmental, behavioral or emotional conditions and who also require health and related services of a type or amount beyond that required by children generally;
- (12) “Commissioner” means the Commissioner of Public Health or the commissioner’s designated representative;
- (13) “Conspicuous place” means an area that is easy to notice;
- (14) “Contracted services” means services provided that are subject to a written agreement;
- (15) “Construction” means the act or process of building;
- (16) “Days” means calendar days unless otherwise noted;
- (17) “Dental hygienist” means an individual licensed to practice dental hygiene in this or another state;
- (18) “Dentist” means an individual licensed to practice dentistry in this or another state;
- (19) “Department” means the Connecticut Department of Public Health or any duly authorized representative thereof;
- (20) “Developmentally appropriate practice” means a framework for working with young children to apply current knowledge about how children develop based upon age and the individual needs of each child;

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(21) “Director” means the program administrator or person responsible for the day to day administrative operation of the program, who may be the head teacher;

(22) “Disability” means a physical or mental impairment that substantially limits one or more major life activities;

(23) “Early childhood education consultant” means an individual who is a credentialed early childhood specialist with an Associate, Bachelors, Masters, or Doctoral degree in early childhood education, child development or human development or a four (4) year degree in a related field with at least twelve (12) credits in child development or early childhood education from an accredited college or university, who has two (2) or more years experience administering a licensed child day care center that meets standards comparable to those in Connecticut;

(24) “Emergency medical technician” means an individual certified in accordance with section 19a-179 of the Connecticut General Statutes or licensed in another state;

(25) “Employment” means working at a child day care center or group day care home and includes volunteers and alternate staff, who work more than twelve (12) times per year;

(26) “Endorsement” means the specific services for which a program has applied, have been approved by the department and are listed on the face of the license;

(27) “Enrollment” means the number of children registered and who have been admitted to the child day care center or group day care home for any given period of time;

(28) “Expansion” means an increase in the physical size or licensed capacity of the child day care center or group day care home;

(29) “Facility” means the building in which the child day care center or group day care home is housed;

(30) “First aid course” means a specified program of emergency treatment that has been approved by the department as listed in section 19a-79-4a(e) of the Regulations of Connecticut State Agencies;

(31) “Group day care home” means a program of supplementary care for not less than seven (7) nor more than twelve (12) related or unrelated children on a regular basis, or that meets the definition of a family day care home as provided in section 19a-77 of the general statutes except that it operates in a facility other than a private family home;

(32) “Group size” means the maximum number of children allowed to be cared for together at a given time in a specific area;

(33) “Head teacher” means the person responsible for the day to day educational portion of the child day care center or group day care home who shall be on site for sixty (60) percent of the hours the center is in operation on a weekly basis, who may also be the director;

(34) “Health consultant” means a physician, physician assistant, advanced practice registered nurse or registered nurse holding a current and valid license in this or another state;

(35) “Ill child” means one who is excluded from a child care program or school due to discomfort, injury or other symptoms of short term contagious illness;

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(36) “Investigational drug” means any medication with an approved investigation new drug application on file with the federal Food and Drug Administration (FDA), that is being scientifically tested and clinically evaluated to determine its efficacy, safety and side effects and that has not yet received FDA approval;

(37) “Job description” means a written outline developed for each position in the facility, containing the qualifications, duties, responsibilities and accountability required of all employees in that position;

(38) “Legal representative” means a person authorized by the operator to represent and act on behalf of the operator, including but not limited to, the signing of licensure applications and renewals;

(39) “License” means the form of permission issued by the department that authorizes the operation of a child day care center or group day care home;

(40) “Licensed capacity” means the maximum number of children allowed under the license to be in the licensed premises at any one time;

(41) “Licensed premises” means the space identified in the license application in which child day care services are provided;

(42) “Local director of health” means the person appointed as the director of health for a city, town or borough pursuant to section 19a-200 of Connecticut General Statutes or for a health district pursuant to section 19a-242 of the Connecticut General Statutes;

(43) “Meal” means the food served and eaten in one sitting containing the four (4) food groups;

(44) “Medication” means any legend or nonlegend drug as defined in section 20-571, including controlled substances, as defined in section 21a-240 of the Connecticut General Statutes;

(45) “Night care” means the care provided for one (1) or more hours between the hours of 10:00 P.M. and 5:00 A.M.;

(46) “Medication error” means failure to administer medication to a child, or failure to administer medication within one (1) hour of the time designated by the prescribing practitioner, or failure to administer the specific medication prescribed for a child, or failure to administer the medication by the correct route or failure to administer the medication according to generally accepted medical practices or failure to administer the correct dosage of medication;

(47) “Operator” means a person, group of persons, association, organization, corporation, institution or agency, public or private, who has the legal responsibility for the overall operation of the child day care center or group day care home and to whom the license is issued;

(48) “Paramedic” means an individual licensed in accordance with section 20-206*ll* of the Connecticut General Statutes or in another state;

(49) “Parent(s)” means the person(s) responsible for the child and may include the legally designated guardian(s) of such child;

(50) “Physician” means a doctor of medicine or osteopathy licensed to practice medicine

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in this or another state;

(51) “Physician assistant” means an individual who is licensed in accordance with section 20-12b of the Connecticut General Statutes and regulations adopted thereunder;

(52) “Primary health care provider” means the person who is responsible for the health care of the child outside the center;

(53) “Professional development” means attendance at classes, seminars, workshops, conferences or forums, and participation in distance learning activities that improve one’s knowledge, skills and abilities;

(54) “Program” means the group of services and activities provided in the child day care center or group day care home;

(55) “Program space” means the defined area within a child day care center or group day care home in which a safe nurturing environment planned in accordance with the age, group size and child staff ratio promotes physical, social, emotional and cognitive development;

(56) “Program staff” means those persons, sixteen (16) years of age or older, responsible for the direct care of children;

(57) “Quarterly” means approximately once every three months;

(58) “Registered dietitian” means a person certified as a dietitian-nutritionist in this or another state;

(59) “Registered nurse” means a person with a license to practice as a registered nurse in Connecticut in accordance with chapter 378 of the Connecticut General Statutes;

(60) “Renovation” means remodeling or revision that changes the physical plant of the licensed space;

(61) “School age” means at least five (5) years of age by January 1 of the current school year, and less than thirteen (13) years of age or less than nineteen (19) years of age with special needs requiring the child to receive supplementary care, and attending school;

(62) “Semi-annual” means two times per calendar year, approximately six (6) months apart;

(63) “Services” means those specific activities that contribute to the health, education and welfare of the children;

(64) “Snack” means a light meal containing two (2) food groups;

(65) “Social service consultant” means a person who holds a baccalaureate degree in social work with at least one (1) year of social work experience under social work supervision, or a baccalaureate degree in a field that the commissioner deems related to social work with at least two (2) years of social work experience under social work supervision;

(66) “Staff” means personnel including volunteers, sixteen (16) years of age or older, who provide a service to a child day care center or a group day care home;

(67) “Staff child ratio” means the maximum number of children per program staff person;

(68) “Supervision” means the direction and on-site observation of the functions and activities of staff or children;

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(69) “Supplementary care” means out-of-home care where an individual or organization takes responsibility for the child’s activities; and,

(70) “Vector” means an organism that carries pathogens from one individual or object to another such as flies, mosquitoes, ticks and rodents.

(Effective July 27, 1993; Amended August 8, 1995; Amended November 3, 1997; Amended April 29, 2002; Amended November 6, 2008)

Sec. 19a-79-2a. Licensure procedures

(a) No person, group of persons, association, organization, corporation, institution or agency, public or private, shall operate a child day care center or group day care home without a license issued by the department in accordance with sections 19a-77 through 19a-87, of the Connecticut General Statutes and 19a-79a-1a through 19a-79-13, of the Regulations of Connecticut State Agencies.

(b) Application for licensure

(1) Application for the initial granting or renewal of a license to operate a child day care center or a group day care home shall be on forms provided by the department.

(2) The application for initial licensure shall be signed by the operator, who shall be twenty (20) years of age or older if the operator is an individual, or by the legal representative of the operator if the operator is a group of persons, association, organization, corporation, institution or agency, public or private, and shall contain the following information:

(A) a notarized original affidavit on a form supplied by the department;

(B) the name of the child day care center or the group day care home and address and telephone number (and mailing address, if different);

(C) the name, home address(es) and home phone number(s) of the operator, if the operator is an individual, or of the legal representative of the operator, if the operator is a group of persons, association, organization, corporation, institution or agency, public or private;

(D) a copy of the current fire marshal certificate of approval, written verification of compliance with state and local building codes, local zoning requirements and local health ordinances;

(E) proposed licensed capacity;

(F) ages of children to be served;

(G) days, hours and months of program operation;

(H) criminal checks and a check of the State Child Abuse Registry as required by section 19a-79-4a(b) of the Regulations of Connecticut State Agencies; and

(I) all other documentation that the commissioner deems necessary to establish that the licensee will meet the health, educational and social needs of the children likely to attend the child day care center or group day care home.

(c) Issuance and renewal of a license

(1) Upon determination by the department that a child day care center or group day care

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home is in compliance with the state statutes and regulations and local health codes pertaining to its licensure, the department shall issue a two (2) year license for all new programs.

(2) Renewal of a license shall be contingent upon payment of the licensure fee for the period specified in section 19a-80 of the Connecticut General Statutes.

(3) The license shall be issued to the operator in the name of the child day care center or group day care home and premises as listed on the affidavit. The license shall not be transferable.

(4) Each license shall list:

(A) the operator,

(B) the location,

(C) the licensed capacity,

(D) the name of the child day care center or group day care home,

(E) the date of expiration of the license, and

(F) the services offered.

(5) The license shall be posted in a conspicuous place in the child day care center or group day care home in an area accessible to the public.

(6) Each operator who desires to make application for a license shall submit a complete application to the commissioner at least sixty (60) days prior to the anticipated date of opening.

(7) At least every two (2) years, the commissioner and the local health director shall make unannounced visits, inspections or investigations of a licensed child day care center or group day care home, including viewing the records required by section 19a-79-1a to section 19a-79-13, inclusive, of the Regulations of Connecticut State Agencies.

(8) If a completed application for renewal of the license has been submitted in a timely manner to the department, but has not been acted upon by the commissioner, the license shall be valid until the commissioner makes a decision on such application.

(d) Civil Penalties and Other Disciplinary Remedies

(1) In accordance with the procedures set forth in sections 19a-79(b) and 19a-84 of the Connecticut General Statutes, if the department finds that the operator of a child day care center or group day care home has failed to substantially comply with section 19a-79-1a to section 19a-79-13, inclusive, of the Regulations of Connecticut State Agencies, the department may, following a contested case hearing only, take any of the following actions, singly or in combination, against the license of the operator:

(A) revocation of the license;

(B) suspension of the license for a specific time period, or until regulatory compliance is secured or conditions deemed necessary to protect the health, safety and welfare of the children cared for in the child day care center or group day care home are met;

(C) the imposition of a civil penalty of up to one hundred dollars (\$100.00) per day for each day of violation of sections 19a-79-1a to 19a-79-13, inclusive, of the Regulations of Connecticut State Agencies; or

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(D) place the license on probationary status and impose such conditions or corrective measures which the department deems necessary to assure the health, safety and welfare of the children cared for in the child day care center or group day care home, including, but not limited to:

(i) reporting regularly to the department upon the matters, which are the basis of probation;

(ii) placement of restrictions upon the operation of the child day care center or group day care home deemed necessary to protect the health, safety and welfare of the children cared for in the facility; and,

(iii) continue or renew professional education until a satisfactory degree of skill has been attained in those areas which are the basis for the probation.

(2) The commissioner may initiate action against a license, whenever in the judgment of the commissioner, the operator or a person who has an ownership interest or serves as an officer, corporate director, managing member or managing partner of the operator:

(A) fails or previously failed to substantially comply with:

(i) all applicable federal, state or local laws;

(ii) ordinances or regulations related to the building, health, fire protection, safety, sanitation or zoning codes;

(iii) sections 19a-79-1a to section 19a-79-13, inclusive, of the Regulations of Connecticut State Agencies; or

(iv) sections 19a-87b-1 to section 19a-87b-18, inclusive, of the Regulations of Connecticut State Agencies.

(B) knowingly furnishes or makes any false or misleading statements to the department in order to obtain or retain the license.

(3) The commissioner may refuse to grant a license to an applicant whenever, in the judgment of the commissioner, the applicant:

(A) fails or previously failed to substantially comply with:

(i) all applicable federal, state or local laws;

(ii) ordinances or regulations related to the building, health, fire protection, safety, sanitation or zoning codes;

(iii) sections 19a-79-1a to section 19a-79-13, inclusive, of the Regulations of Connecticut State Agencies; or

(iv) sections 19a-87b-1 to section 19a-87b-18, inclusive, of the Regulations of Connecticut State Agencies.

(B) knowingly furnishes or makes any false or misleading statements to the department in order to obtain the license.

(C) For the purposes of this section, the history of a licensee of which an officer, corporate director, managing member or managing partner of the applicant or the applicant had an ownership interest or served as an officer, corporate director, managing member or managing partner shall be considered as attributable to the applicant in assessing compliance under subparagraph (A) of this subdivision.

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(4) The licensee has a right to a hearing regarding any licensure action as stated in section 19a-84 of the Connecticut General Statutes.

(5) The child day care center or group day care home shall notify the parent(s) of the children using the child day care center or group day care home within twenty-four (24) hours of the department's revocation or suspension order.

(6) After issuance of the commissioner's decision to suspend or revoke a license to operate, the license shall be surrendered to the department on demand.

(e) Voluntary surrender of license

(1) At least thirty (30) days prior to the voluntary termination of day care services the department and the parent(s) shall be notified in writing by the child day care center or group day care home of its intended date of closing.

(2) When a child day care center or group day care home discontinues the operation for which it is licensed, a written notice of the closing accompanied by the license shall be sent to the commissioner within ten (10) days after the date of closing. Such a child day care center or group day care home shall be inspected and licensed before reopening for operation.

(Effective July 27, 1993; Amended March 4, 1999; Amended March 29, 2001; Amended March 8, 2004; Amended November 6, 2008)

Sec. 19a-79-3a. Administration

(a) The operator of the child day care center or group day care home shall be responsible for compliance with the requirements of sections 19a-79-1a to section 19a-79-9a, inclusive, and section 19a-79-13 of the Regulations of Connecticut State Agencies and applicable endorsements in sections 19a-79-10 to section 19a-79-12, inclusive, in such a manner as to ensure the safety, health and development of the children while in the operator's care.

(b) The operator shall be responsible for the overall management and operation of the child day care center or group day care home in accordance with applicable state and local laws and regulations and shall:

(1) provide and maintain a safely equipped physical plant,

(2) provide programs and services to meet the needs of the children,

(3) employ staff and substitute staff in accordance with section 19a-79-4a of the Regulations of Connecticut State Agencies,

(4) submit for the commissioner's approval the required qualifications and experience of the head teacher on the forms provided,

(5) develop and implement a written organizational chart that establishes a clear line of authority,

(6) define in writing and ensure the performance of the duties and responsibilities of all staff classifications,

(7) require participation by new staff in employee orientation, and assure annual training for all current staff on the child day care center or group day care home policies, plans and procedures, and

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(8) be responsible for managing child behavior using techniques based on developmentally appropriate practice and communicate acceptable techniques to all staff.

(A) The operator and staff shall manage child behavior using techniques based on developmentally appropriate practice, including positive guidance, redirection and setting clear limits that encourage children to develop self-control, self-discipline and positive self-esteem.

(B) The operator shall document that the techniques used to manage child behaviors in the facility have been discussed with the child's parent(s) prior to enrollment and reviewed as needed during the period of the child's enrollment.

(C) While children are in attendance at the program the operator and staff shall not engage in, nor allow, abusive, neglectful, physical, corporal, humiliating or frightening treatment or punishment, and shall not tie nor bind children and shall not physically restrain children except for the protection and safety of the child or others, using least restrictive methods, as appropriate.

(D) The operator and staff shall not engage in, nor allow, anyone else to engage in any sexual activity with the day care children while in attendance at the program.

(E) The operator and staff shall report actual or suspected child abuse or neglect, or the imminent risk of serious harm of any child to the Department of Children and Families as mandated by section 17a-101 to section 17a-101e, inclusive, of the Connecticut General Statutes.

(c) The operator shall notify the department, the parent(s) and staff of any changes in programs or services.

(1) Notification of personnel changes shall be made within five (5) business days after the change.

(A) If the change is for a head teacher, a plan for interim head teacher coverage shall be submitted to the department.

(B) A qualified head teacher or a plan approved by the commissioner shall be in place within thirty (30) days of change of a qualified head teacher.

(2) Notification of changes related to the licensed capacity, fees, services or voluntary closing shall be made at least thirty (30) days prior to the effective date of the proposed change. A change of location, change of operator or a change of ownership requires a new initial application.

(d) The operator shall implement and annually review specific written policies, plans and procedures required by any applicable statute or regulation. The operator shall notify the parent(s), staff and the department within five (5) days of changes in these policies, plans and procedures. The policies, plans and procedures shall include, but not necessarily be limited to:

(1) daily attendance records for both children and staff, recorded daily at the time of arrival and departure and kept on file at the facility for at least two (2) years, showing the specific times of arrival and departure;

(2) discipline as referenced in section 19a-79-3a(b)(8) including, but not necessarily

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limited to:

(A) positive guidance, redirection, setting clear limits and continuous supervision by staff during disciplinary action;

(B) the prohibition of abusive, neglectful, physical, corporal, humiliating or frightening treatment or punishment and physical restraint, unless such restraint is necessary to protect the health and safety of the child or others;

(C) child abuse and neglect, including child protection and mandated reporting;

(3) when a child is not picked up as planned, including, but not necessarily limited to:

(A) staffing of at least two (2) staff eighteen years of age or older on the licensed premises,

(B) time frames (for when the policy will be implemented),

(C) parent(s) or emergency contacts,

(D) alternate pick up person,

(E) notification of police department;

(4) emergencies, including, but not necessarily limited to:

(A) medical emergencies, including, but not necessarily limited to, a personal emergency, accident or illness, designation of a licensed physician or hospital emergency service to be available, transportation to medical services and notification of the parents;

(B) fire emergencies, including, but not necessarily limited to, identification of means of egress, roles and responsibilities of staff, designated safe location for reconvening and notification of the parents;

(C) weather related emergencies, including, but not necessarily limited to, closings, a safe location for children, resources available and notification of the parent(s);

(D) evacuation, including, but not necessarily limited to, transportation, location of an alternate shelter, community resources and notification of the parent(s);

(5) supervision of children, including, but not necessarily limited to:

(A) group size,

(B) ratio of staff to children,

(C) indoor and outdoor supervision,

(D) nap time,

(E) bathroom areas;

(6) a copy of both section 19a-87a of the Connecticut General Statutes, which concerns civil penalties against operators and criminal conviction of an operator or a person employed in a child day care center or group day care home in a position connected with the provision of care to a child receiving child day care services, and section 53-21 of the Connecticut General Statutes, which concerns injury or risk of injury to, or impairing morals of children;

(7) general operating policies, including, but not necessarily limited to:

(A) admission which includes a health record and the ages of children enrolled,

(B) agreements with the parent(s),

(C) parent(s) involvement,

(D) medication policies if applicable,

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- (E) content and times of meals and snacks,
- (F) provisional enrollment period,
- (G) days and hours of operation, including sick days, holidays and vacations,
- (H) withdrawal and expulsion of children,
- (I) access to the program and facility; and,
- (8) personnel policies, including, but not necessarily limited to:
 - (A) job descriptions,
 - (B) employee benefits,
 - (C) supervision and discipline of staff,
 - (D) probationary period of staff,
 - (E) communication with the parent(s).
- (e) The operator shall post the following items in a conspicuous place, accessible to the public:
 - (1) the license,
 - (2) the current fire marshal certificate,
 - (3) the department complaint procedure,
 - (4) food service certificate as required by the local director of health,
 - (5) menus,
 - (6) emergency plans,
 - (7) no smoking signs at entrances,
 - (8) the most recent department inspection report posted for thirty (30) of the program's operating days and,
 - (9) radon test results.
- (f) The parent(s) shall have immediate access to the child day care center or group day care home during the hours of operation, unless otherwise prohibited by law.
- (g) The operator shall keep on file for a two (2) year period at the child day care center or group day care home all inspection reports, the current licensing application and correspondence related to licensure which shall be available to the parent(s) and the department on request.
- (h) Failure to grant the department immediate access to the child day care center or group day care home, its staff or its records or failure to provide the department with documentation obtained by the facility about child abuse or neglect or conviction records, upon request of the department, shall be grounds for suspension or revocation of the license or denial of issuance or renewal of the license. The operator may deny access to facility inspections if department staff fails to show official identification.
- (i)
 - (1) The operator shall notify the parent(s), if the department issues a notice of hearing for the suspension or revocation of the license pursuant to section 19a-84 of the Connecticut General Statutes, of the proceeding and the alleged violation. The notification to parents shall be in writing and sent by United States mail, certified or registered, postage prepaid, return receipt requested not later than ten (10) days before the scheduled hearing date. The

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operator shall demonstrate compliance with this subsection at the commencement of the hearing. Inability to do so shall be construed as a substantial failure to comply with the regulations and may constitute an additional basis for suspension or revocation of the license in that proceeding without a new statement of charges.

(2) In addition to the requirements of this section of the Regulations of Connecticut State Agencies, the operator shall notify the parent(s) in writing of the final decision of the department if one is rendered, within fourteen (14) days of the receipt of the decision.

(j) The operator shall provide to the department copies of all service contracts or current agreements with consultants, practitioners and agencies used on a regular or consultative basis in the delivery of services within ten (10) days after execution of said contract or agreement. Any changes in said contracts or agreements shall be reported to the department within ten (10) days.

(k) The operator shall enroll only children for whom the child day care center or group day care home is licensed to provide services. No services that require an endorsement shall be provided without the applicable endorsement from the department. Categories for licensure are:

- (1) six (6) weeks to three (3) years,
- (2) preschool (three (3) years to five (5) years),
- (3) school age, and
- (4) night care.

(l) For September, October, November and December enrollment only, a child who will be three (3) on or before January 1, may be enrolled as a three year old. At any other time of the year a three (3) year old must have had his or her third (3rd) birthday to be considered a three (3) year old.

(m) The operator shall be responsible for compliance with all applicable motor vehicle laws when transporting children enrolled in any child day care center or group day care home.

(Effective July 27, 1993; Amended November 6, 2008)

Sec. 19a-79-4a. Staffing

(a) A file shall be kept on the licensed premises for each employee of the child day care center or group day care home which shall include:

(1) a medical statement signed by a physician, advanced practice registered nurse or physician assistant, completed within twelve (12) months before the date of employment for new staff, and every twenty-four (24) months for current staff and at any other time requested by the commissioner, such statement to document the presence of any known medical or emotional illness or disorder that would currently pose a risk to children in care or would currently interfere with effective functioning as an employee of a child day care center or group day care home;

(2) upon employment, a written report of a negative tuberculin test completed within twelve (12) months prior to the date of employment or for a known prior reactor, no

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evidence of active tuberculosis on a chest x-ray;

(3) documentation of professional development for each program staff person who cares for the children, including new employee orientation and annual training for current staff on the child day care center or group day care home policies, plans and procedures; and

(4) disciplinary actions.

(b) For each prospective employee, the file shall include:

(1) a completed state and a completed federal fingerprint card shall be submitted to the department for a State Police Bureau of Identification and a Federal Bureau of Investigation Criminal Records check;

(2) a completed form approved by the department shall be submitted to the department for a check of the state child abuse registry; and

(3) the operator shall provide to the department any information obtained concerning substantiated child abuse or neglect records or criminal convictions, upon request of the department.

(c) The operator shall maintain a staff adequate for the number, ages and developmental needs of the children to be accommodated.

(1) A designated head teacher shall be on site for sixty percent (60%) of the time the child day care center or group day care home is in operation on a weekly basis.

(2) There shall be at least two (2) staff eighteen (18) years of age or older on the premises when one (1) or more children are in attendance. The staff shall be available to care for the children.

(3) All staff in the child day care center and group day care home shall have the personal qualities necessary to:

(A) care for and work with children,

(B) relate to adults, and

(C) relate to the parent(s).

(4) Proper staff child ratios shall be maintained at all times.

(A) There shall be at least one (1) program staff person for every ten (10) children, or fraction thereof in attendance.

(B) When there is a mixed age group, the lower required ratio for the age of the youngest child shall prevail.

(C) When children are participating in swimming or wading as part of the program, whether at the facility or on a field trip, the following staff child ratios, at a minimum, shall be maintained at all times with the children:

(i) all non-swimmers shall be clearly identified as non-swimmers in a way that is visually and easily recognized by lifeguards and staff;

(ii) for infants twelve (12) months of age and younger, there shall be at least one (1) program staff person with every child who is in direct physical contact with the child;

(iii) for toddlers under three (3) years of age, there shall be at least one (1) program staff member with every two (2) children;

(iv) for preschool children (three (3) years to five (5) years of age) there shall be at least

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one (1) program staff member with every four (4) children; and

(v) for school-age children there shall be at least one (1) program staff member with every six (6) children.

(D) The operator shall be responsible for assuring the supervision of the children at all times while the children are at the facility, indoors or outdoors, or on field trips. At no time shall a child be left unsupervised.

(5) Group size shall be maintained at all times.

(A) The group size shall not exceed twenty children.

(B) When there is a mixed age group, the smaller required group size shall prevail.

(6) During nap time, when all of the children in the group are sleeping, the overall staff child ratios shall be maintained on the licensed premises. At no time shall a group of children be left unsupervised.

(d) Programs shall have the following staff:

(1) The child day care center or group day care home shall maintain documentation on site that there is a designated director. Any director hired or newly designated on or after January 1, 2010 shall have within one (1) year of being hired or designated at least three (3) credits in the administration of early childhood education programs or educational administration from an institution of higher education accredited by the Board of Governors of Higher Education or from a regionally accredited institution of higher education. Any person designated as director at a specific facility prior to January 1, 2010 shall not be required to meet such educational requirements for director for the duration of their employment as director at that facility.

(2) A designated head teacher shall submit to the department written verification of being twenty (20) years of age or older, having the personal qualifications needed to supervise people, and having either:

(A) in a child day care center,

(i) a high school diploma or equivalency certificate, and

(ii) at least one thousand and eighty (1080) hours of documented supervised experience over a nine (9) month span of time, including working with children in a program with these standards or comparable standards in this or another state, which program serves children of the same ages and developmental stages who are served at the child day care center, and one of the following: a current center-based Child Development Associate Credential issued from the Council for Early Childhood Professional Recognition, or twelve (12) credits in early childhood education or child development from an accredited institution of higher education with program approval from the Board of Governors of Higher Education or

(iii) approval by the department as a head teacher prior to January 1, 1994;

(B) in a group day care home,

(i) a high school diploma or equivalency certificate, and

(ii) at least one thousand and eighty (1080) documented hours of experience over a nine (9) month span of time working with unrelated children of the same ages and developmental stages to be served in this group day care home; or

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(C) in a child day care center or group day care home,

(i) a four (4) year college degree in early childhood education or child development from an accredited institution of higher education with program approval from the Board of Governors of Higher Education, and

(ii) at least three hundred sixty (360) hours of documented supervised experience in working with unrelated children of the same age(s) to be served in this child day care center or group day care home with these standards or comparable standards in this or another state and at least one (1) semester of student teaching with children of the same age(s) and developmental stages that are served in the child day care center or group day care home.

(3) A second program staff person who works under supervision of the head teacher shall be eighteen (18) years of age or older and have at least one of the following:

(A) a high school diploma, or

(B) an equivalency certificate, or

(C) at least five hundred and forty (540) hours documented experience in working with unrelated children of the same age(s) to be served in this child day care center or group day care home.

(4) Other program staff shall be able to work under supervision and shall be at least sixteen (16) years of age.

(5) Additional program staff shall be sufficient to provide care of children during all hours of operation in keeping with group size and ratio.

(6) When children are participating in swimming or wading as part of the program, whether at the facility or on a field trip, there shall be a qualified program staff member present and directly supervising the children who shall be at least twenty (20) years of age and who is certified in cardiopulmonary resuscitation in accordance with section 19a-79 of the Connecticut General Statutes. The operator shall verify that there is a person directly supervising the children who holds a current lifeguard certification accepted by the department.

(e)

(1) At all times the child day care center is in operation there shall be present at least one (1) staff member who has current certification in cardiopulmonary resuscitation (CPR) in accordance with section 19a-79 of the Connecticut General Statutes, appropriate for all of the children served at the child day care center.

(2) In addition, at all times the child day care center or group day care home is in operation, there shall be present at least one (1) staff member who has successfully completed within the past three (3) years a department approved first aid course that meets the following requirements:

(A) It shall be at least six (6) hours in length.

(B) Instruction shall include, but not necessarily be limited to:

(i) the recognition and emergency management of bleeding, burns, poisoning, anaphylaxis, respiratory distress including choking, musculo-skeletal injury, seizures, wounds including insect bites, head injuries, shock, loss of consciousness, dental

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emergencies, child abuse and sexual abuse;

(ii) communicable disease prevention, recognition and management, which includes: a discussion of transmission through the intestinal tract, the respiratory system and direct contact; hygiene, including hand washing, cleaning and disinfection; diapering techniques; signs and symptoms of illness, including fever, rash and vomiting; temperature taking; education in specific communicable disease, including, but not necessarily limited to, diarrheal diseases, bacterial meningitis, chicken pox, hepatitis, strep throat, head lice, scabies and vaccine-preventable diseases; and

(iii) accident prevention and safety including, but not necessarily limited to: safety for the indoor environment and outdoor play area, first aid supplies, child restraint systems and seat belt safety in accordance with section 14-100a of the Connecticut General Statutes and section 14-100a-1 of the Regulations of Connecticut State Agencies.

(C) Instruction shall be provided by a person who meets at least one of the following requirements:

(i) a first aid instructor currently certified by the American Red Cross, American Safety and Health Institute, Medic First Aid International, Inc., National Safety Council or an American Heart Association Heartsaver Instructor or BLS Instructor,

(ii) a physician, physician assistant, advanced practice registered nurse or registered nurse licensed in this or another state or

(iii) an emergency medical technician or paramedic.

(D) The course outline and all other written materials used in the course shall be submitted to the department and shall not be used without approval by the department.

(f) The child day care center or group day care home shall keep on file written verification of compliance with subsection (e) of this section for each staff member who the child day care center or group day care home designates to meet the requirements of such subsection. Such verification shall be maintained for three (3) years after the date that staff member completed first aid training for group day care homes and child day care centers, or CPR training as required for child day care centers only. Verification shall include:

(1) written verification or certification in CPR from an organization specified in accordance with section 19a-79(a)(5) of the Connecticut General Statutes that is signed and dated by a representative of the specified organization; and

(2) written verification of first aid training by a representative of the organization, physician, physician assistant, advanced practice registered nurse, registered nurse, emergency medical technician or paramedic who conducted the training.

(g) Professional development for program staff shall be required for one (1) per cent of the total annual hours worked. Such education may include, but is not limited to, early childhood education and child development, licensing and regulations, health issues, nutrition, first aid, social services, child abuse laws and programming for children with disabilities or special health care needs.

(1) The operator of the child day care center or group day care home shall develop,

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implement and maintain a written plan for professional development in child care.

(2) The operator shall have documentation of a professional development plan for each program staff member which shall be maintained on site at the facility and made available for review.

(h) A written plan for consultation services shall be developed, signed annually by the consultant and implemented.

(1) These services shall include:

(A) an early childhood educational consultant available to the operator and staff for advice and support regarding the educational content of the program; anyone approved as an early childhood consultant prior to January 1, 2009, will continue to be an approved early childhood educational consultant, except for good cause shown. Program staff shall not serve as early childhood educational consultants for programs in which they provide direct care or direct program supervision in a non-consultative role;

(B) a health consultant available to the operator and staff for advice regarding the health of the children and the health program;

(C) a dentist or dental hygienist consultant available to the operator and staff for advice regarding the dental health of children or a dental health education program;

(D) a social service consultant available to the operator and staff for advice regarding the emotional needs, staff support and the social service program; and

(E) a registered dietitian consultant available to the operator and staff for advice regarding nutrition and food service for those programs that serve meals.

(2) Consultative service shall include, but not necessarily be limited to:

(A) annual review of written policies, plans and procedures;

(B) annual review of education programs;

(C) availability by telecommunication for advice regarding problems;

(D) availability, in person, of the consultant to the program;

(E) consulting with administration and staff about specific problems;

(F) acting as a resource person to staff and the parent(s);

(G) documenting the activities and observations required in this subsection in a consultation log that is kept on file at the facility for two (2) years; and

(H) specific duties of the health consultant shall include, but not be limited to:

(i) making, at a minimum, quarterly site visits to facilities that serve children three (3) years of age and older; or for group day care homes, facilities that operate no more than three (3) hours per day, or facilities that enroll only school age children, semi-annual site visits. Facilities that are closed during the summer months may omit the summer quarterly visit. Site visits shall be made by the health consultant during customary business hours when the children are present at the facility;

(ii) reviewing health and immunization records of children and staff;

(iii) reviewing the contents, storage and plan for maintenance of first aid kits;

(iv) observing the indoor and outdoor environments for health and safety;

(v) observing children's general health and development;

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(vi) observing diaper changing and toileting areas and diaper changing, toileting and hand washing procedures;

(vii) reviewing the policies, procedures and required documentation for the administration of medications, including petitions for special medication authorizations needed for programs that administer medication; and

(viii) assisting in the review of individual care plans for children with special health care needs or children with disabilities, as needed.

(3) The commissioner, with good cause shown, may deny or revoke a consultant's approval status as a consultant to licensed child day care centers and group day care homes.

(Effective July 27, 1993; Amended August 8, 1995; Amended March 4, 1999; Amended December 23, 2002; Amended November 6, 2008)

Sec. 19a-79-5a. Record keeping

(a) The operator of a child day care center or group day care home is responsible for maintaining on the licensed premises a current record for each child enrolled. A copy of the record shall be available and provided upon request to the department, the child's parent(s) and the local health director. It shall include, but not necessarily be limited to:

(1) enrollment information and permission forms signed and dated by the parent(s) that shall include, but not necessarily be limited to:

(A) the child's name, address, date of birth and date enrolled;

(B) the residence, business address(es) and telephone number(s) of the parent(s);

(C) the name and telephone number of the child's physician or other primary health care provider;

(D) specific written permission forms signed by the parent(s) authorizing:

(i) the operator to use previously selected emergency policies as described in section 19a-79-3a(d)(4) of the Regulations of Connecticut State Agencies, which shall accompany the child on trips away from the premises;

(ii) the name and telephone number of one responsible person other than the parent(s) who can remove the child from the child day care center or group day care home;

(iii) any activity away from the premises;

(iv) transportation services;

(2) a health record that shall include, but not necessarily be limited to:

(A) date of birth;

(B) except as provided in subsection (b) of this section, a physical examination form signed by a physician, physician assistant or advanced practice registered nurse documenting an examination completed within one (1) year prior to enrollment, and yearly from the date of the initial physical examination thereafter, with a thirty-day allowance, which form shall provide:

(i) a statement about the child's general health and the presence of any known medical or emotional illness or disorder that would currently pose a risk to other children or which would currently affect this child's functional ability to participate safely in a day care setting;

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and

(ii) a statement that the child has been screened for risk factors for tuberculosis, as defined by the American Academy of Pediatrics, and for those children with identified risk factors, evidence that the child has been screened for latent tuberculosis infection and if infected, whether they have been treated for such infection;

(C) an immunization record that includes the month, day and year of each immunization required for admission as specified in subdivision (1) of subsection (d) of section 19a-79-6a of the Regulations of Connecticut State Agencies and such documentation as is required to confirm age appropriate immunization, immunization in progress or exemption to immunization as defined in subdivision (3) of subsection (d) of section 19a-79-6a of the Regulations of Connecticut State Agencies. The immunization record and said documentation of immunizations shall be submitted to the department upon request;

(D) copies of the health records acceptable to the local education authority and the local director of health, where children of school age are enrolled; and

(E) information regarding disabilities or special health care needs such as, allergies, special dietary needs, dental problems, hearing or visual impairments, chronic illness, developmental variations or history of contagious disease, and an individual plan of care for a child with special health care needs or disabilities, developed with the child's parent(s) and health care provider and updated, as necessary. Such plan shall include appropriate care of the child in the event of a medical or other emergency and shall be signed by the parent(s) and staff responsible for the care of the child.

(3) Injury, illness and accident reports:

(A) The facility shall produce and maintain on the premises, for a period of not less than two years, a written record of all injuries or accidents that result in an injury to a child or illness of a child enrolled at the facility that occur on or off site as part of the child day care program. The report shall include a description of the injury, illness or accident, the date, time of occurrence and location and any action taken by the facility including, but not limited to, whether the child was transported to a hospital emergency room, doctor's office or other medical facility. The written report for an individual child shall be available to the department and a copy shall be provided to the child's parent(s) no later than the next business day.

(B) The licensee shall notify the department no later than the next business day of:

(i) the death of a child enrolled at the facility, if the child died while at the facility, or at a facility sponsored event; and

(ii) any injury of a child that occurs while the child is at the facility, or at a facility sponsored event, that results in the child's admission to a hospital.

(C) The licensee of a child day care center or group day care home shall report each case occurring at the facility of any disease listed on the commissioner's list of reportable diseases and laboratory findings issued pursuant to section 19a-2a of the Connecticut General Statutes to local health officials and the department in accordance with sections 19a-36-A3 and 19a-36-A4 of the Regulations of Connecticut State Agencies.

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(b) The physical examination requirements of section 19a-59-5a (a)(2)(B) shall be waived when such examination is contrary to the religious beliefs and practices of the child or the parent(s) of such child, or when a child has been displaced from their place of residence due to a declared state of emergency by a state or federal official who has the authority to make such declaration, and existing physical examination records are inaccessible for a period not to exceed six (6) months, unless an extension is approved by the department. A statement requesting such waiver shall be submitted and shall be maintained in the child's health record. Such statement shall be signed by the parent(s). The parent(s) shall certify that he or she accepts complete responsibility for the health of the child and that, to the best of the parent's knowledge, the child is in good health.

(Effective July 27, 1993; Amended August 8, 1995; Amended August 29, 1996; Amended March 8, 2004; Amended November 6, 2008)

Sec. 19a-79-6a. Health and safety

(a) Food service

(1) Transportation of food(s) not prepared on the premises shall satisfy the minimum requirements of section 19-13-B49 of the Regulations of Connecticut State Agencies.

(2) A nutritionally adequate meal as recommended by The United States Department of Agriculture, 7 Code of Federal Regulations 226.20, as amended, shall be provided by the child day care center or group day care home, or the parent(s) whenever a child remains on the premises for five (5) hours or more.

(A) Children who stay on the premises less than five (5) hours shall have a nutritious snack.

(B) Children who stay on the premises longer than five (5) but less than eight (8) hours shall have one (1) meal and one (1) nutritious snack.

(C) Children who stay on the premises eight (8) hours or more shall have one (1) meal plus two (2) nutritious snacks, or two (2) meals plus one (1) nutritious snack.

(3) There shall be proper refrigeration of no more than forty-five (45) degrees Fahrenheit for perishable foods in all child day care centers and group day care homes and on field trips.

(4) When a child day care center or group day care home provides either meals or snacks, menus shall be prepared at least one (1) week in advance, dated and copies posted in a conspicuous place. Changes shall be documented by the end of the program day. A copy of what was served shall be kept on file for three (3) months.

(5) All areas used for the preparation and serving of meals in child day care centers shall be maintained in accordance with sanitary practices and procedures as set forth in section 19-13-B42 of the Regulations of Connecticut State Agencies.

(6) The kitchen in child day care centers or group day care homes that is used for the preparation and serving of food to children shall be clean, well lighted and ventilated, protected by window screening and provided with hot and cold running water, adequate and safe storage for food and supplies and refrigeration.

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(7) Separate hand washing facilities shall be located convenient to the room where food is prepared in child day care centers and group day care homes.

(8) All multi-use eating and drinking utensils shall be thoroughly washed, rinsed and sanitized after each use in child day care centers and group day care homes.

(9) The kitchen in child day care centers or group day care homes shall not be used as a playroom, but may be used for a specific program activity room under supervision. It shall be separated by a door or a gate from the rooms used by the children in the child day care center or group day care home to prevent them from entering the kitchen except under supervision.

(10) Children in child day care centers or group day care homes shall not be left unsupervised during meal preparation.

(11) Children and staff shall wash their hands with soap and water before eating or handling food.

(b) Procedures in case of illness

(1) Staff members shall be knowledgeable about signs and symptoms of childhood illness and shall be responsible for the initial observation of each child upon arrival and continued observation throughout the day for such signs and symptoms.

(2) Any child showing suspicious signs or symptoms of short-term contagious illness shall be placed in a designated isolation area with continual visual supervision by staff. The parent(s) or other authorized adult shall be called immediately to remove the child from the child day care center or group day care home.

(c) The facility shall maintain at least one (1) portable, readily available first aid kit wherever children are in care, including field trips, outdoor play areas and one to remain at the facility if all the children do not attend the field trip. Each kit shall be a closed container for storing first aid supplies, accessible to staff at all times but out of the reach of children. First aid kits shall be restocked after use, and an inventory shall be conducted at least monthly. The first aid kit shall contain at least the following items:

- (1) assorted sizes of non medicated adhesive strips;
- (2) sterile, individually wrapped, three (3) or four (4) inch gauze squares;
- (3) a two (2) inch gauze roller bandage;
- (4) one (1) roll of adhesive tape (hypoallergenic);
- (5) scissors;
- (6) tweezers;
- (7) two (2) instant cold packs;
- (8) a non-glass thermometer to measure a child's temperature with plastic covers for the thermometer or alcohol to clean the thermometer, or single use Tempa Dots;
- (9) two (2) triangular bandages with safety pins;
- (10) disposable, nonporous gloves;
- (11) a current American Academy of Pediatrics (AAP) standard first aid chart, or current (less than five (5) years in print) first aid manual, chart or guide provided by an approved first aid course for children and adults; and

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(12) CPR mouth barrier (face shield).

(d) **First aid supplies for field trips shall also include:**

(1) water;

(2) reliable communication device;

(3) liquid soap;

(4) emergency contact numbers for each child;

(5) medications, as needed, if the program administers medications; and

(6) plastic bags, for storage.

(e) **Immunization requirements**

(1) A child seeking admission to or attending a child day care center or group day care home shall be protected as age-appropriate by adequate immunization against diphtheria, pertussis, tetanus, poliomyelitis, measles, mumps, rubella, hemophilus influenzae type b, hepatitis b if such child was born after December 31, 1993, and varicella if such child was born after December 31, 1996 and against any other disease for which vaccination is recommended in the current schedule for active immunization adopted by the commissioner in accordance with section 19a-7f of the Connecticut General Statutes.

(2) The operator shall admit no child to a child day care center or group day care home unless such child's parent(s) furnishes documentation of age-appropriate immunization, immunization-in-progress or exemption from immunization as specified in subdivision (3) of this subsection. No child shall be permitted to continue to attend a child day care center or group day care home for more than thirty (30) days unless such child continues to meet said requirements of subdivision (3) of this subsection.

(3) For each enrolled child, the operator shall obtain from the child's parent(s) and keep on file at the child day care center or group day care home one or more of the following types of documentation for each of the diseases listed in subdivision (1) of this subsection:

(A) a statement signed and dated by a physician, physician assistant or an advanced practice registered nurse indicating that the child is current or in progress with immunizations according to the schedule adopted by the commissioner in accordance with section 19a-7f of the Connecticut General Statutes and that names the appointment date for the child's next immunization;

(B) a statement signed and dated by a physician, physician assistant or an advanced practice registered nurse indicating that the child has an appointment that will keep the immunizations current or in progress as required by said schedule and that names the date for the child's next immunization;

(C) a statement signed and dated by a physician, physician assistant or an advanced practice registered nurse indicating that the child has laboratory confirmed proof of immunity to natural infection, or, in the case of varicella, a statement signed and dated by a physician, physician assistant or an advanced practice registered nurse indicating that the child has already had chickenpox based on family or medical history;

(D) a statement signed and dated by a physician, physician assistant or an advanced practice registered nurse indicating that the child has a medical contraindication to

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immunization;

(E) a written statement that immunization is contrary to the religious beliefs and practices of the child or the parent(s) of such child. Such statement shall be signed by the child's parent(s); or

(F) a written statement from the child's parent(s) that the child has been displaced from their place of residence due to a declared state of emergency by a state or federal official who has the authority to make such declaration, and existing immunization records are inaccessible and the child is current with their immunizations, or a statement signed and dated by a physician, physician assistant, or an advanced practice registered nurse indicating that the child has an appointment that shall keep the immunizations current or in progress as required by said schedule.

(4) For each child to whom subparagraph (B) or (F) of subdivision (3) of this section applies, continued enrollment in day care for more than thirty (30) days after the named immunization appointment shall be contingent on the operator receiving written documentation from a physician, physician assistant or an advanced practice registered nurse stating either: that the named appointment was kept and the child received the scheduled immunizations, or that the child was unable to receive the scheduled immunizations for medical reasons and a new appointment date is named.

(Effective July 27, 1993; Amended August 29, 1996; Amended December 28, 1999; Amended November 6, 2008)

Sec. 19a-79-7a. Physical plant

(a) The standards established by the following sources for the construction, renovation, alteration, expansion, conversion, maintenance and licensure of child day care centers and group day care homes, as they are amended from time to time, are incorporated and made a part of this section by reference:

- (1) State of Connecticut Basic Building Code,
- (2) State of Connecticut Fire Safety Code,
- (3) State of Connecticut Public Health Code,
- (4) local codes and ordinances.

(b) Plans for new construction, expansion, renovation or conversion, indicating the proposed use and accompanied by a written narrative shall be submitted to the department prior to the start of construction.

(1) Completed plans and specifications shall be submitted to and reviewed by the department on the basis of compliance with the Public Health Code.

(2) Written approval by the local building inspector, local director of health or designee, local zoning and local fire marshal shall be submitted to the department, upon request of the department.

(3) Approval by the department is required prior to the use of any space that has been newly constructed, expanded, renovated or converted.

(4) All construction, remodeling, renovation, repairs or alterations of structures shall be

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done in such a manner to prevent hazards or unsafe physical or environmental conditions during periods of operation.

(c) General requirements

(1) Any operator is responsible for maintaining the child day care center or group day care home in compliance with section 19a-79-1a to section 19a-79-13, inclusive, of the Regulations of Connecticut State Agencies.

(2) The building, equipment and services shall be maintained in a good state of repair. A maintenance program shall be established that ensures that the interior, exterior and grounds of the building are maintained, kept clean and orderly, free from accumulations of refuse, dampness, stagnant water, dilapidated structures and other health and safety hazards.

(3) Water supply, food service and sewage disposal facilities shall be in compliance with all applicable sections of the Public Health Code.

(A) All water supplies shall be tested every two (2) years for lead content and the results submitted to the local and state health departments.

(B) Whenever water is obtained from other than a department-approved public water supply, it shall be of a safe and sanitary quality and tested every two (2) years for bacterial and chemical quality and the results submitted to the local and state health departments.

(C) Sanitary drinking fountains or individual disposable drinking cups shall be provided and accessible to the children at all times.

(d) Basic requirements

(1) Emergency vehicles shall have access to all child day care centers or group day care homes.

(2) Established walkways shall be provided and properly maintained for each entrance and exit leading to a driveway or street.

(3) In child day care centers that are licensed by January 1, 1994, a toilet and sink shall be designated for use by the staff and other adults. In child day care centers that are licensed or renovated after January 1, 1994, a room with a toilet and sink within the licensed child day care center shall be designated for the exclusive use of staff and other adults.

(4) All windows that open to the outside and are used for ventilation shall be equipped with sixteen (16) mesh screening, and shall be protected to prevent falls.

(5) Any unprotected glass doors, windows or mirrors to which children have access shall be protected to a height of thirty six (36) inches from the floor or surface on which a child stands.

(6) Where overhead doors are accessible to the children, they shall be equipped with locking devices and spring protectors.

(7) Exit doorways, stairs or hallways shall not be blocked by furniture, toys or play equipment.

(8) There shall be an area available for the individual storage of each child's clothing and bedding.

(9) Smoking is prohibited in all child day care centers or group day care homes and outdoor areas except in designated smoking areas, provided these areas are separate,

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properly ventilated and enclosed away from any children present at the facility. Signs shall be posted, visible to the public, on entrance to the facility indicating that smoking is prohibited except in designated areas. Matches and lighters shall be inaccessible to children at all times.

(10) Electrical outlets shall be provided with safety covers or approved safety outlets. The use and maintenance of electrical cords, appliances and adaptors shall be in full compliance with state codes.

(11) Toilet and washing facilities

(A) Where toilets and sinks are shared by children and adults, a written policy shall be developed and implemented that requires supervision of children when using the shared toilet room.

(B) Programs shall provide changing and sanitary facilities appropriate to meet the individual needs of children who are enrolled at the facility who need assistance with toileting or who are not independent with toileting.

(C) For programs serving children under six (6) years of age there shall be at least one (1) toilet and one (1) sink with hot and cold running water for every sixteen (16) children, or fraction thereof. Standard size toilets and sinks shall be adapted for children's use. Facilities using potty chairs in addition to the required toilets shall ensure that they are of a nonporous, synthetic product, and emptied into the toilet, cleaned and disinfected after each individual use.

(D) For programs serving only school age children, there shall be at least one (1) toilet and one (1) sink with running water for every twenty-five (25) children, or fraction thereof. Toilet facilities shall be designed in such a manner to allow individual privacy.

(E) Sinks with running water shall be readily accessible to the toilet rooms if not located within them. Toilet tissue, soap, single use disposable towels and a waste receptacle shall be accessible to the toilets and sinks. Staff and children shall wash their hands with soap and water after toileting.

(F) Each toilet room shall be well lighted and ventilated to the outside atmosphere.

(G) In child day care centers constructed or renovated after January 1, 1994, all toilet facilities shall be mechanically ventilated to the outside atmosphere.

(e) Environmental requirements

(1) Every area used by children shall be adequately ventilated and have a thermometer affixed to the wall. The ambient air temperature shall be at least sixty-five (65) degrees Fahrenheit as measured three (3) feet from the floor.

(2) When the temperature exceeds eighty (80) degrees Fahrenheit, the operator shall provide more fluids and increase ventilation.

(3) The water heating equipment shall deliver water at the tap, the temperature of which shall be within a range of sixty (60) degrees Fahrenheit to one hundred fifteen (115) degrees Fahrenheit. It shall have the capacity to deliver the required amounts at all times in conformance with the State of Connecticut Basic Building Code.

(4) Only central heating or permanently installed heating systems shall be used. Portable

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space heaters are prohibited.

(5) Walls, ceilings, floors and rugs shall be maintained in a state of good repair and be washable or easily cleanable. Rugs, if used, shall be secured to the floor.

(6) Hot water or steam pipes located in areas accessible to children shall have adequate protective covering which is maintained safely and in good repair.

(7) Each level of the child day care center or group day care home shall be provided with a telephone in working order located within the licensed program space accessible to staff for emergency purposes. Emergency telephone numbers shall be posted in an area adjacent to the phone.

(8) All spaces occupied by people, equipment within buildings, approaches to buildings and parking lots shall have a minimum of one (1) foot candle of lighting per square foot.

(9) Child day care centers and group day care homes shall have at least fifty (50) foot candles of light per square foot in rooms used by children for reading, painting and other close work. There shall be at least thirty (30) foot candles of light in other work or play areas. In child day care centers and group day care homes constructed or renovated after January 1, 1994, all rooms and toilet rooms shall have at least one (1) light fixture switch at each entrance. All areas accessible to children shall have light fixtures that are shielded or shatter proof.

(10) Potentially hazardous substances in the child day care centers and group day care homes shall be stored in a separate locked area.

(11) Garbage and rubbish shall be kept in containers constructed of durable material approved by the local health director. Receptacles shall be in good repair to prevent infestations by rodents, insects and other pests and to prevent odors, injuries and other nuisance conditions. The garbage and rubbish shall be moved to an exterior waste storage area at least daily.

(12) Stairs must be properly protected and maintained in good repair. There must be handrails installed at a height usable by children.

(13) Toxic plants and materials are prohibited in areas accessible to children.

(14) Any pet or animal present at the facility, indoors or outdoors, shall be in good health, show no evidence of carrying disease and be a friendly companion for the children.

(15) When pets are kept on the premises, procedures for their care and maintenance and access to the children shall be written and implemented.

(16) There shall be effective measures taken to prevent vermin from entering or breeding in the child day care center or group day care home. All openings to the outer air used for ventilation shall be screened with a minimum of sixteen (16) mesh screening and doors shall be provided to prevent the entrance of vectors.

(17) If the child day care center or group day care home uses the basement level or the first floor of a building, a minimum of one (1) radon test shall be conducted using a device or service listed by the National Radon Proficiency Program and approved by the department.

(A) This test shall be completed during the months of November through April and the

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results posted with the license. The department and the local director of health shall be notified of the results.

(B) When confirmatory sampling results of radon gas in the air are equal to or greater than 4.0 picocuries per liter (pCi/L), the operator shall ensure that the radon gas is reduced to below 4.0 pCi/L. A qualified residential mitigation service provider as defined in sections 19a-14b and 20-420 of the Connecticut General Statutes shall be hired to reduce the level of radon gas in the air.

(18) Child day care centers and group day care homes that utilize combustible fuel shall be equipped with at least one (1) operable carbon monoxide (CO) detector on each occupied level of the facility. CO detectors shall comply with Underwriters Laboratories (UL) Standards for Safety, and shall be operated in accordance with the manufacturer's instructions.

(f) Program space

(1) The requirements of this subdivision shall apply to a child day care center or group day care home operating in a facility first licensed after January 1, 1986.

(A) The operator shall provide a minimum of thirty-five (35) square feet of total indoor usable program space per child. The total licensed capacity shall be determined on a room-by-room basis measuring from interior wall to interior wall.

(B) Within the allowance for total indoor usable program space, there may be furniture used by other individuals as well as the children; but there shall be open program space available which allows for freedom of movement by the children.

(C) The following items shall be deducted from the total indoor usable square footage of program space:

- (i) bathrooms, hallways, kitchen and food service areas;
- (ii) refrigerators;
- (iii) heating and cooling units;
- (iv) staff desks and storage units;
- (v) any space or equipment used for other than the activities of the children; and
- (vi) large indoor activity room.

(2) The requirements of this subdivision shall apply to a child day care center or group day care home operating in a facility first licensed before January 1, 1986.

(A) The operator shall provide a minimum of thirty (30) square feet of total indoor usable program space per child. Measurements to determine total indoor usable program space shall be taken from interior walls.

(B) Such space shall be free of furniture except that needed for the children's purposes, exclusive of toilet rooms, bathrooms, coat rooms, kitchens, halls, isolation room or other rooms used for purposes other than the activities of the children.

(3) Cots, cribs and playpens shall be placed so that walkways are clear for emergencies and evacuation.

(g) Equipment. All equipment shall be of such design and material as to be readily cleaned and safe for children.

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(1) Equipment shall not be colored or covered by any poisonous material. All solid constituents of paint for equipment and toys, and pigment coloring in paints, pencils, crayons and inks, to be used by the children shall be non-toxic. Equipment shall be sturdy, safely constructed and free from protruding nails, rust, toxic material and other hazards.

(2) Adequate equipment for rest shall be provided. An individual cot shall be provided for any child who regularly remains five (5) hours or longer per day. When cots are shared, they shall be washed and disinfected and linens changed between children. In a group day care home, an individual mat or individual sleeping bag may be substituted for the individual cot.

(3) Metal equipment shall be free from rust or chipping paint.

(4) Hardware such as air conditioners, water heaters or fuse boxes shall be inaccessible to children.

(5) The materials and equipment available and used by children shall be developmentally appropriate for the ages of the children served.

(h) Outdoor play space

(1) There shall be access to a minimum of seventy-five (75) square feet per child of outdoor space for the number of children using the space at any one time. This could include parks, school yards, parking areas or elevated or roof top play areas. The outdoor area shall be fenced or protected for safety.

(2) Where swings, seesaws or climbing apparatus are used, the surface in the space shall be protected with a minimum of eight (8) inches of impact absorbing materials, e.g., sand or its equivalent.

(3) The playground shall be free of glass, debris, holes and other hazards.

(4) Nuts, bolts and screws shall be tight; and those that protrude shall be covered or protected.

(5) Outside equipment shall be anchored for stability. Anchors shall be buried below ground level.

(6) The operator shall provide documentation to the department, upon request, by a certified playground safety inspector that newly constructed playgrounds and all newly installed playground equipment that are set in position and anchored in such a way to last indefinitely are designed and installed in accordance with U.S. Consumer Product Safety Commission and the American Society for Testing and Materials Standards.

(7) The outdoor play area shall be protected from traffic, bodies of water, gullies and other hazards by barriers in a manner safe for children.

(A) Fences used to protect children from hazards shall be at least four (4) feet in height.

(B) When there is a swimming pool or any other body of water at the facility or near enough to the facility to attract or be accessible to children at any time of the year, there shall be a sturdy fence or barrier, four (4) feet high or higher, with locked entrances, which totally and effectively bars access to the water by children.

(C) On and after January 1, 2010, a rooftop used as a play area shall be enclosed with a wall, fence or permanent physical barrier not less than six (6) feet high and the bottom edge

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shall be no more than three and one half (3 ½) inches from the base or floor. The wall, fence or permanent physical barrier shall be designed to prevent children from climbing it.

(8) Drinking water shall be available and accessible.

(9) Outdoor equipment shall be arranged in such a way as to avoid accidents.

(i) **Public swimming pools, wading and public swimming areas.** Public swimming pools, wading and public swimming areas if provided, shall comply with the provisions of sections 19-13-B33b and 19a-36-B61 of the Regulations of Connecticut State Agencies. No wading pools shall be used. No day care child shall be permitted in a hot tub, spa or sauna. Hot tubs, spas and saunas shall be locked and inaccessible to children.

(j) No dangerous weapon as described in section 53-206 of the Connecticut General Statutes or facsimile of a firearm as defined in section 53-206c of the Connecticut General Statutes shall be permitted on the premises of the child day care center or group day care home unless the carrier of such weapon or facsimile firearm is a peace officer as defined in section 53a-3 of the Connecticut General Statutes.

(Effective July 27, 1993; Amended August 8, 1995; Amended November 6, 2008; Amended March 17, 2014)

Sec. 19a-79-8a. Educational requirements

Each child day care center and group day care home shall develop and implement a written plan for the daily program that includes a flexible schedule and shall be available to the parent(s) and staff. Child day care centers and group day care homes shall have policies, procedures and activities that meet and enhance the individual needs of the diverse population of children served, which includes children with cultural, language and developmental differences.

(a) The plan shall include:

(1) indoor and outdoor physical activities which provide opportunities for fine and gross motor development;

(2) problem-solving experiences that facilitate concept formation, language development and sensory discrimination;

(3) creative experiences which allow children the opportunity to develop and express their own ideas and feelings in all parts of the program, including, but not necessarily limited to:

(A) art and media,

(B) dramatic play,

(C) music,

(D) language, and

(E) motor activity;

(4) language learning experiences that provide opportunities for spontaneous conversation, as well as experiences with books, poems, stories and songs;

(5) experiences that promote self-reliance and build self-esteem, including, but not necessarily limited to, self care of body and clothing, care of possessions and shared group

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responsibility for equipment and materials;

(6) health education experiences that include modeling good health practices, sound nutrition and safety awareness.

(b) The program shall include:

(1) child-initiated and teacher-initiated activities;

(2) exploration and discovery;

(3) varied choices for children in materials and equipment;

(4) individual and small group activities;

(5) active and quiet play;

(6) rest, sleep or quiet activity;

(7) nutritious snacks and meals; and

(8) toileting and clean up.

(Effective July 27, 1993; Amended November 6, 2008)

Sec. 19a-79-9. Repealed

Repealed November 3, 1997.

Sec. 19a-79-9a. Administration of medications

Group day care homes and child day care centers that administer medications of any kind shall comply with all requirements of this section and shall have written policies and procedures at the facility governing the administration of medications which shall include, but not be limited to, the types of medication that shall be administered, parental responsibilities, staff responsibilities, proper storage of medication and record keeping. Said policies and procedures shall be available for review by the commissioner during site inspections or upon demand and shall reflect best practice. A group day care home or child day care center shall not deny services to a child on the basis of a child's known or suspected allergy or because a child has a prescription for an automatic pre-filled cartridge injector or similar automatic injectable equipment used to treat an allergic reaction or for injectable equipment used to administer glucagon. A group day care home or child day care center shall not deny services to a child on the basis of a child's diagnosis of asthma or because a child has a prescription for an inhalant medication to treat asthma.

(a) Administration of Nonprescription Topical Medications Only

(1) Description

For the purposes of this section nonprescription topical medications shall include, but not be limited to:

(A) diaper changing or other ointments free of antibiotic, antifungal or steroidal components;

(B) medicated powders; and

(C) teething, gum or lip medications.

(2) Nonprescription Topical Medications Administration/Parent Permission Records

The written permission of the parent(s) shall be required prior to the administration of

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the nonprescription topical medication and a medication administration record shall be written in ink and kept on file at the facility for each child administered a nonprescription topical medication. The medication administration record and the parent(s) permission shall become part of the child's health record when the course of medication has ended. The parent(s) shall be notified of any medication administration errors immediately in writing and the error shall be documented in the record. The following information shall be included on a form as part of the medication administration record:

- (A) the name, address and date of birth of the child;
 - (B) the name of the medication;
 - (C) the schedule and site of administration of the medication;
 - (D) a statement indicating that the medication has been previously administered to the child without adverse effect;
 - (E) the signature in ink of the director, head teacher, program staff or group day care home provider receiving the parent permission form and the medication;
 - (F) the name, address, telephone number, signature and relationship to the child of the parent(s) authorizing the administration of the medication;
 - (G) the date and time the medication is started and ended;
 - (H) medication administration errors; and
 - (I) the name of the person who administered the nonprescription topical medication.
- (3) Nonprescription Topical Medications/Labeling and Storage

(A) The medication shall be stored in the original container and shall contain the following information on the container or packaging indicating:

- (i) the individual child's name;
 - (ii) the name of the medication; and
 - (iii) directions for the medication's administration.
- (B) The medication shall be stored away from food and inaccessible to children.
- (C) Any unused portion of the medication shall be returned to the parent(s).

(b) Administration of Medications Other Than Nonprescription Topical Medications

(1) Training Requirements

(A) Prior to the administration of any medication, the director(s), head teacher(s), program staff or group day care home provider(s) who are responsible for administering the medications shall first be trained by a physician, physician assistant, advanced practice registered nurse or registered nurse in the methods of administration of medications and shall receive written approval from the trainer which indicates that the trainee has successfully completed a training program as required herein. A director, head teacher, program staff or group day care home provider trained and approved to administer medication shall also be present whenever a child who has orders to receive medication is enrolled and present at the facility.

(B) The training in the administration of medications shall be documented and shall include, but not be limited to, the following:

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- (i) objectives;
- (ii) a description of methods of administration including principles and techniques, application and installation of oral, topical and inhalant medication, including the use of nebulization machines, with respect to age groups;
- (iii) administering medication to an uncooperative child;
- (iv) demonstration of techniques by the trainer and return demonstration by participants, assuring that the trainee can accurately understand and interpret orders and carry them out correctly;
- (v) recognition of side effects and appropriate follow up action;
- (vi) avoidance of medication errors and the action to take if an error occurs;
- (vii) abbreviations commonly used;
- (viii) documentation including parent permission, written orders from physicians and the record of administration;
- (ix) safe handling including receiving medication from the parent(s), safe disposal and standard precautions; and
- (x) proper storage including controlled substances, in accordance with section 21a-262-10 of the Regulations of Connecticut State Agencies.

(C) The facility shall have staff trained in the administration of inhalant medication used to treat asthma on site during all hours when a child who has a diagnosis of asthma and who has a prescription for an inhalant medication to treat asthma is on-site.

(D) *Injectable Medications*

In addition to the above training, before a director, head teacher, program staff or group day care home provider may administer injectable medications, he shall have successfully completed a training program on the administration of injectable medications by a premeasured, commercially prepared syringe. The trainer, who shall be a physician, physician assistant, advanced practice registered nurse or registered nurse, shall assure that the director, head teacher, program staff or group day care home provider understands the indications, side effects, handling and methods of administration for injectable medication. Thereafter, on a yearly basis, the director, head teacher, program staff or group day care home provider shall have their skills and competency in the administration of injectable medication validated by a physician, physician assistant, advanced practice registered nurse or registered nurse. Injectable medications shall only be given in emergency situations, by a premeasured commercially prepared syringe, unless a petition for special medication authorization is granted by the department. The facility shall have staff trained in the use of an automatic prefilled cartridge injector or similar automatic injectable equipment used to treat an allergic reaction on site during all hours when a child with a prescription for an automatic prefilled cartridge injector or similar automatic injectable equipment used to treat an allergic reaction is on-site.

(E) A program staff member currently certified by the State of Connecticut Department of Developmental Services, formerly the Department of Mental Retardation, to administer medications shall be considered qualified to administer medications for the modalities in

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which they have been trained at child day care centers or group day care homes.

(2) Training Approval Documents/Training Outline

(A) Upon completion of the required training program, the physician, physician assistant, advanced practice registered nurse or registered nurse who conducted the training shall issue a written approval to each director, head teacher, program staff or group day care home provider who has demonstrated successful completion of the required training. Approval for the administration of oral, topical and inhalant medications shall remain valid for three (3) years. Approval for the administration of injectable medications shall be valid for one (1) year. A copy of the approval shall be on file at the facility where the director, head teacher, program staff or group day care home provider is employed and shall be available to department staff upon request.

(B) The written approval shall include:

(i) the full name, signature, title, license number, address and telephone number of the physician, physician assistant, advanced practice registered nurse or registered nurse who gave the training;

(ii) the location and date(s) the training was given;

(iii) a statement that the required curriculum areas listed in subparagraphs (B) and (D) of subdivision (1) of this subsection when applicable were successfully mastered, and indicating the route(s) of administration the trainee has been approved to administer;

(iv) the name, address and telephone number of the director, head teacher, program staff or group day care home provider who completed the training successfully; and

(v) the expiration date of the approval.

(C) The trainer shall provide the trainee with an outline of the curriculum content which verifies that all mandated requirements have been included in the training program. A copy of said outline shall be on file at the facility where the trainee is employed for department review. The department may require at any time that the operator obtain the full curriculum from the trainer for review by the department.

(3) Order From An Authorized Prescriber/Parent's Permission

(A) Except for nonprescription topical medications described in section 19a-79-9a(a) (1) of the Regulations of the Connecticut State Agencies, no medication, prescription or nonprescription shall be administered to a child without the written order of an authorized prescriber and the written permission of the child's parent(s) which shall be on file at the facility for at least two (2) years after the child is no longer attending the program. Such medications may include:

(i) oral medications;

(ii) topical medications;

(iii) inhalant medications; or

(iv) injectable medications, by a premeasured, commercially prepared syringe, to a child with a medically diagnosed condition who may require emergency treatment.

(B) The written order from an authorized prescriber shall be on one form that indicates that the medication is for a specific child and that contains the following information:

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- (i) the name, address and date of birth of the child;
- (ii) the date the medication order was written;
- (iii) the medication or drug name, dose and method of administration;
- (iv) the time the medication is to be administered;
- (v) the date(s) the medication is to be started and ended;
- (vi) relevant side effects and the authorized prescriber's plan for management if they occur;
- (vii) notation if the medication is a controlled drug;
- (viii) a listing of any allergies, reactions to or negative interactions with foods or drugs;
- (ix) specific instructions from the authorized prescriber who orders the medication regarding how the medication is to be given;
- (x) the name, address and telephone number of the authorized prescriber ordering the drug;
- (xi) the authorized prescriber's signature; and
- (xii) the name, address, telephone number, signature and relationship to the child of the parent(s) giving permission for the administration of the drug by the director, head teacher, program staff or group day care home provider.

(C) If the authorized prescriber determines that the training of the director, head teacher, program staff or group day care home provider is inadequate to safely administer medication to a particular child, or that the means of administration of medication is not permitted under these regulations, that authorized prescriber may order that such administration be performed by licensed medical personnel with the statutory authority to administer medications.

(D) The director, head teacher, program staff or group day care home provider shall administer medication only in accordance with the written order of the authorized prescriber and shall not administer the first dose of any medication, except in an emergency. The parent(s) shall be notified of any medication administration errors immediately in writing and the error shall be documented in the record.

(E) Investigational drugs shall not be administered.

(4) Required Records

(A) Except for nonprescription topical medications described in section 19a-79-9a(a)(1), individual written medication administration records for each child shall be written in ink, reviewed prior to administering each dose of medication and kept on file at the facility for at least two (2) years after the child is no longer attending the program. The medication administration record shall become part of the child's health record when the course of medication has ended.

(B) The individual written administration record for each child shall include:

- (i) the name, address and date of birth of the child;
- (ii) the name of the medication or drug;
- (iii) the dosage ordered and method of administration;
- (iv) the pharmacy and prescription number if applicable;

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- (v) the name of the authorized prescriber ordering the drug;
- (vi) the date, time and dosage at each administration;
- (vii) the signature in ink of the director, head teacher, program staff or group day care home provider giving the medication;
- (viii) food and medication allergies;
- (ix) level of cooperation from the child in accepting the medication;
- (x) the date and time the medication is started and ended; and
- (xi) medication administration errors.

(5) Storage and Labeling

(A) Medication shall be stored in the original child-resistant safety container. The container or packaging shall have a label which includes the following information:

- (i) the child's name;
- (ii) the name of the medication;
- (iii) directions for the medication's administration; and
- (iv) the date of the prescription.

(B) Except for nonprescription topical medications described in subdivision (1) of subsection (a) of this section, automatic prefilled cartridge injectors, or similar automatic injectable equipment used to treat an allergic reaction, injectable equipment used to administer glucagon or an inhalant medication to treat asthma and over the counter medications prescribed as an emergent first line of defense medication against an allergic reaction, medication shall be stored in a locked area or a locked container in a refrigerator in keeping with the label directions away from food and inaccessible to children. Keys to the locked area or container shall be accessible only to personnel authorized to administer medication. Controlled drugs shall be stored in accordance with section 21a-262-10 of the Regulations of Connecticut State Agencies.

(C) Equipment and medications prescribed to treat asthma, administer glucagons, or as an emergent first line of defense medication against an allergic response shall be stored in a safe manner, inaccessible to other children, to allow for quick access in an emergency.

(D) All unused or expired medication shall be returned to the parent(s) or disposed of if it is not picked up within one (1) week following the termination of the order, in the presence of at least one witness. The facility shall keep a written record of the medications destroyed which shall be signed by both parties.

(E) The facility shall require the parent(s) of a child who has a prescription for an automatic prefilled cartridge injector, or similar automatic injectable equipment used to treat an allergic reaction or injectable equipment used to administer glucagon or inhalant medication to treat asthma, to provide the injector or equipment labeled with the information from the prescriber upon enrollment and attendance of such child at the facility, and replace such medication and equipment prior to its expiration date.

(6) Children enrolled at the facility may self administer medications with documented parental and authorized prescriber's permission. Children may request and receive assistance from staff in opening containers or packages or replacing lids. Children who self administer

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medications shall be able to identify and select the appropriate medication by size, color, amount or other label identification; know the frequency and time of day for which the medication is ordered; and consume the medication appropriately. Medication to be self administered shall be stored in accordance with section 19a-79-9a(b)(5) of the Regulations of Connecticut State Agencies.

(7) Petition For Special Medication Authorization

(A) The operator of a child day care center or group day care home may petition the department to administer medications to a child cared for at the child day care center or group day care home by a modality which is not specifically permitted under these regulations by submitting a written application to the department including the following information:

(i) a written order from an authorized prescriber containing the information for the specific child set forth in subdivision (3)(B) of this subsection and a statement that the administration by the requested modality is the only reasonable means of providing medication and that the administration must occur during hours of the child's attendance at the facility;

(ii) a written training plan including the full name, signature, title, license number, address and telephone number of the physician, advanced practice registered nurse, physician assistant or registered nurse who shall provide the training, a detailed outline of the curriculum areas to be covered in training and a written statement by the authorized prescriber that the proposed training is adequate to assure that the medication shall be administered safely and appropriately to the particular child;

(iii) name, address and telephone number of the person(s) who shall participate in the training;

(iv) written permission from the child's parent(s); and

(v) such other information that the department deems necessary to evaluate the petition request.

(B) After reviewing the submitted information, if the department determines that the proposed administration of medication for the particular child can be provided in a manner to assure the health, welfare and safety of the child, it may grant the petition. The department may grant the petition with any conditions or corrective measures which the department deems necessary to assure the health, safety and welfare of the child. The department shall specify the curriculum that the training program shall cover and the expiration date of the authorization provided in granting the petition. If the department grants the petition, no medication may be administered until after the proposed training program has been successfully completed and a written certification from the physician, physician assistant, advanced practice registered nurse or registered nurse who provided the training is submitted to the department. The certification shall include:

(i) the full name, signature, title, license number, address and telephone number of the physician, physician assistant, advanced practice registered nurse or registered nurse who provided the training;

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- (ii) the location and date(s) the training was given;
- (iii) a statement that the curriculum approved by the department was successfully mastered and stating the modality of administration of medication that the trainee has been approved to administer; and
- (iv) the name, address and telephone number of the person(s) who successfully completed the training.

(C) Copies of all documentation required under this subsection shall be maintained at the facility. The requirements of subsection (b) (4) and (b) (5) of this section shall apply to the administration of medication authorized by petition.

(c) Cease and Desist Orders

If the department determines that the health, safety or welfare of a child in the child day care center or group day care home imperatively requires emergency action to halt the administration of medications by a director, head teacher, program staff or group day care home provider in a child day care center or group day care home, the department may issue a cease and desist order requiring the immediate cessation of the administration of medications by a director, head teacher, program staff or group day care home provider in the facility. The department shall provide an opportunity for a hearing regarding the order within ten (10) business days of date the order is issued. Upon receipt of the order, the operator shall cease the administration of all medications and provide immediate notification to the parent(s) of all children under his care that no medications may be administered at the child day care center or group day care home until such time as the cease and desist order is terminated.

(d) Emergency Distribution of Potassium Iodide

Notwithstanding any other provisions of the Regulations of Connecticut State Agencies, during a public health emergency declared by the Governor pursuant to section 19a-131a of the Connecticut General Statutes and if authorized by the Commissioner of Public Health via the emergency alert system or other communication system, a child day care center or group day care home licensed in accordance with section 19a-80 of the Connecticut General Statutes and located within a ten (10) mile radius of the Millstone Power Station in Waterford, Connecticut shall permit designated staff members to distribute and administer potassium iodide to adults present or to a child in attendance at the child day care center or group day care home during such emergency, provided that:

(1) prior written consent has been obtained by the child day care center or group day care home for such provision. Written consent forms shall be provided by the child day care center or group day care home to the parent(s) of each child currently enrolled or employees currently employed by the child day care center or group day care home promptly upon the effective date of this subdivision. Thereafter, written consent forms shall be provided by the child day care center or group day care home to the parent(s) of each minor child upon enrollment and to each new employee upon hire. Such documentation shall be kept at the facility;

(2) each person providing consent has been advised in writing by the child day care

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center or group day care home that the ingestion of potassium iodide is voluntary;

(3) each person providing consent has been advised in writing by the child day care center or group day care home about the contraindications and the potential side effects of taking potassium iodide, which include:

(A) persons who are allergic to iodine should not take potassium iodide;

(B) persons with chronic hives, lupus or other conditions with hypocomplementemic vasculitis should not take potassium iodide;

(C) persons with Graves disease or people taking certain heart medications should talk to their physician before there is an emergency to decide whether or not to take potassium iodide; and

(D) side effects may include minor upset stomach or rash;

(4) child day care centers and group day care homes shall have designated staff members to distribute and administer potassium iodide to those individuals and minor children for whom prior written consent has been obtained. Such designated staff members shall be eighteen (18) years of age or older and shall have been instructed by the child day care center or group day care home in the administration of potassium iodide. Such instruction shall include, but not be limited to, the following:

(A) the proper use and storage of potassium iodide;

(B) the recommended dosages of potassium iodide to be administered to children and adults as prescribed by the Food and Drug Administration; and

(5) potassium iodide shall be stored in a locked storage area or container, inaccessible to children.

(Adopted effective November 3, 1997; Amended March 8, 2004; Amended January 4, 2005; Amended November 6, 2008)

Sec. 19a-79-10. Under three endorsement

(a) The operator of a program caring for children under three (3) years of age shall comply with section 19a-79-1a to section 19a-79-10, inclusive, and section 19a-79-13 of the Regulations of Connecticut State Agencies.

(b) A program caring for children under three (3) years of age is required to have a separate endorsement by the department.

(c) Infants and toddlers

(1) Age. Children from six (6) weeks to thirty six (36) months of age shall be considered infants and toddlers.

(2) Ratio. There shall be at least one (1) program staff qualified under section 19a-79-4a(d) of the Regulations of Connecticut State Agencies for every four (4) children or fraction thereof in attendance.

(3) Group size. The group size shall not exceed eight (8) children.

(4) There shall be a physical barrier separating each group of eight (8) children, indoors and outdoors.

(d) Special equipment

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Each child day care center and group day care home shall have equipment and furniture to meet the developmental needs of the children served.

(1) Sinks

(A) In child day care centers there shall be a sink with hot and cold running water designated for diaper changing and hand washing of staff and children. This sink shall be located in the program space. Visual contact with all other children shall be maintained while changing diapers or using the sink. Child day care centers which staff three (3) adults to a group size of eight (8) infants or toddlers may use an accessible diaper changing facility if it is immediately adjoining the program area.

(B) Separate sinks shall be available for purposes other than hand washing after diaper changing within child day care centers.

(C) Group day care homes shall have a sink accessible for hand washing other than the sink used for food preparation.

(2) Furniture shall include:

(A) well constructed free standing cribs, not stacked cribs, each of which has slats no more than two and three-eighths ($2\frac{3}{8}$) inches apart and a fully waterproofed, firm, snug-fitting mattress for infants;

(B) washable cots for toddlers;

(C) chairs for feeding, each of which has a stable base, safety straps on all high chairs attached to the chair and a tray which locks securely;

(D) low tables and chairs according to children's size and development; and

(E) a refrigerator and facilities to store and heat food and bottles.

(3) Furniture may include but not be limited to:

(A) strollers, each of which has a stable base, firmly attached safety straps and tightly locking brakes;

(B) play pens, each of which has either small weave mesh netting or slats no more than two and three-eighths ($2\frac{3}{8}$) inches apart, a firm floor with a secured foam pad and hinges that lock tightly; and

(C) an adult rocking chair.

(e) **Diapering and toileting**

(1) The diapering area shall be an elevated sturdy table or counter equipped with a safety rail.

(2) Infants and toddlers shall be diapered at a diapering area used only for this purpose and located in the program area.

(3) Each diapering area shall have a non-porous surface and be kept in good repair.

(4) Diapering areas shall be washed and disinfected after each use.

(5) Disposable paper sheets shall be used and discarded immediately after each diapering.

(6) A covered washable lined waste receptacle shall be available and located in a convenient place for soiled waste material. These materials shall be removed to an exterior waste storage area at least daily.

(7) The hands of the staff and the children shall be washed before and after each diaper

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change.

(8) Diapering and hand washing policies and procedures shall be posted in each diapering area.

(9) Disposable diapers shall be discarded in a covered receptacle immediately after diapering.

(10) When cloth diapers or training pants are used, a plan for their use and care shall be submitted to and approved by the department prior to implementation of the plan. This plan shall include, but not necessarily be limited to, these procedures:

(A) placing soiled clothing and diapers in a sealed air tight container,

(B) removing soiled clothing and diapers from the child day care center or group day care home daily, and

(C) cleaning and sanitizing the container daily.

(f) Linens and clothing and bedding

(1) A supply of linen and emergency clothing shall be available for each child in the child day care center or group day care home at all times.

(2) All children's linens shall be washed at least weekly and as needed.

(3) Each child's linens and clothing shall be stored individually. Plastic bags shall not be accessible to infants and toddlers.

(4) When cribs and cots are shared, they must be washed and disinfected and linens changed between children.

(g) Sleep arrangements

(1) Infants under twelve (12) months of age shall be placed in a supine (back) position for sleeping in a well constructed, free standing crib or bed designed for infant sleeping, with a snug fitting mattress unless the child has written documentation from a physician, physician assistant or advanced practice registered nurse specifying a medical reason for an alternative sleep position.

(2) When infants can easily turn over from the supine to the prone position, they shall be put down to sleep on their back, but allowed to adopt whatever position they prefer for sleep.

(3) Soft surfaces and gas-trapping objects such as pillows, quilts, sheepskins, soft bumpers or stuffed toys shall not be placed under or with an infant for sleeping and shall be kept out of the infant's crib or bed.

(4) No infant shall be put to sleep on a sofa, soft mattress, waterbed or other soft surface. No infant shall be put to sleep in a child restraint system intended for use in a vehicle, an infant carrier, a swing or any place that is not specifically designed to be an infant bed unless the child has written documentation from a physician, physician assistant or advanced practice registered nurse specifying a medical reason for their use.

(h) Toys and other objects

(1) Toys used for infants shall be kept separate, washed and disinfected at least daily. Toys for toddlers, including floor and riding toys, shall be washed and disinfected at least weekly and as needed.

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(2) Toys and other objects with a diameter of less than one and one-quarter (1 ¼) inches, objects with removable parts that have a diameter of less than one and one-quarter (1 ¼) inches, plastic bags, balloons and Styrofoam objects shall not be accessible to children under three (3) years of age.

(i) **Health consultant**

(1) A health consultant shall visit the program on the days and times children under the age of three (3) are present. The scheduled times of the visits shall be arranged so that all children under the age of three (3) are observed. The health consultant shall prepare and maintain signed documentation of visits which shall be kept on the licensed premises.

(2) The health consultant shall visit the program according to the following schedule:

(A) once a week for children up to twenty-four (24) months of age,

(B) once a week for children two (2) to three (3) years of age attending a full day, and

(C) once a month for children two (2) to three (3) years of age attending part day programs.

(j) Infants shall be removed from their cribs and held for all bottle feedings. They may be placed in chairs for all other feedings. Infants and toddlers shall be removed from their cribs or playpens at other intervals during the day for individual cuddlings and for verbal communication. They shall be allowed to crawl and toddle as age and development permit. Each infant shall be placed in a prone (front) position part of the time when awake.

(k) Foods and Liquids. When food and liquids are served:

(1) a written statement specifying the formula, breast milk or other liquids and the feeding schedule for infants shall be obtained from the parent(s),

(2) unused portions of formula, breast milk or other liquids shall be discarded after each feeding,

(3) clean bottles shall be provided by the parent(s) unless the facility uses disposable bottles or has a dishwasher or dishwashing system approved by the local health director to wash bottles,

(4) baby food shall be served from a dish unless the whole contents of the jar will be served, and

(5) each child's bottle shall be individually identified with the child's name.

(l) **Outdoor play space**

(1) All infant toddler play space shall be fenced.

(2) The equipment available to the infants and toddlers shall be developmentally appropriate for the ages of the children.

(Effective July 27, 1993; Amended August 8, 1995; Amended November 6, 2008)

Sec. 19a-79-11. School age children endorsement

(a) The operator of a child day care center or group day care home caring for children of school age shall comply with section 19a-79-1a to section 19a-79-9a, inclusive, section 19a-79-11 and 19a-79-13 of the Regulations of Connecticut State Agencies.

(b) A program providing care for school age children shall have a separate school age

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children endorsement by the department.

(c) The program shall provide adequate opportunities for creative, recreational and restful activities as appropriate to meet the needs of the individual school age child.

(1) These activities shall not be an extension or duplication of the child's school day.

(2) Children shall have opportunities to choose among activities, including, but not necessarily limited to:

(A) free time,

(B) creative activities,

(C) opportunities for homework assignments,

(D) nutritional snacks,

(E) physical activities,

(F) quiet activities,

(G) small group activities,

(H) special events which may include field trips, and

(I) self-concept activities.

(d) There shall be at least one (1) qualified program staff person for each ten (10) children or fraction thereof.

(e) The group size shall not exceed twenty (20) children.

(f) When a program serves school age children only, the designated head teacher shall be on site for sixty percent (60%) of the time the child day care center or group day care home is in operation on a weekly basis, and shall submit written verification of the following qualifications and experiences:

(1) the age of twenty (20) years or older;

(2) the personal qualities needed to supervise others;

(3) a high school diploma or equivalency certificate;

(4) at least five hundred and forty (540) hours of documented supervised experience over at least a nine (9) month span of time including working with children in a program with comparable standards to the standards in this or another state, which program must serve children of the same ages and developmental stages who are served at the child day care center; and

(5) one of the following:

(A) twelve (12) credits in early childhood education or child development, elementary education, recreation, group social work or a related field from an accredited institution of higher education with program approval from the Board of Governors of Higher Education; or

(B) approval by the department as a head teacher prior to January 1, 1994; or

(6) a four (4) year college degree in elementary education, recreation, group social work or a related field from an accredited institution of higher education with program approval from the Board of Governors of Higher Education, with at least two hundred and seventy (270) hours of documented supervised experience working with unrelated children of the same ages to be served in this child day care center or group day care home. This supervised

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experience could be student teaching or a practicum assignment.

(g) The education consultant used in the program shall have training and experience in child development, recreation, leisure activities, group social work or elementary education.

(h) When a program for school age children is located in a public or private school facility currently used as a school, the local health, building and zoning regulations pertaining to school facilities shall apply. Under these circumstances, written verification of building and zoning approval is not required. A fire marshal certificate of approval and written local health approval are required for the facility as defined in section 19a-79-2a(b)(2)(D) of the Regulations of Connecticut State Agencies.

(Effective July 27, 1993; Amended November 6, 2008)

Sec. 19a-79-12. Night care endorsement

(a) The operator of a child day care center or group day care home providing night care shall comply with section 19a-79-1a to section 19a-79-13, inclusive of the Regulations of Connecticut State Agencies.

(b) The program providing care for one (1) or more hours between the hours of ten (10) P.M. and five (5) A.M. shall have a separate night care endorsement by the department.

(1) There shall be a person on the licensed premises designated as the person in charge who shall meet the head teacher qualifications in section 19a-79-4a(d)(2) of the Regulations of Connecticut State Agencies.

(2) There shall be a written plan for program activities to meet the needs of the individual child, including individual sleep patterns and quiet activities.

(3) There shall be a written plan for continuous supervision of sleeping children including cot placement and evacuation from the building.

(4) A child shall not be in care for more than twelve (12) hours in a twenty-four (24) hour period on a regular basis.

(5) All staff persons shall be awake and available to work with children in care.

(6) There shall be an individual cot or crib with bedding for each child, in accordance with section 19a-79-10(d)(2)(A) and 19a-79-10(d)(2)(B) of the Regulations of Connecticut State Agencies. Bunk beds shall not be used.

(A) Sleeping apparel and toiletries shall be individually labeled and stored.

(B) Bedding for children over twelve (12) months of age shall consist of a blanket and sheet or a sleeping bag, with a pillow in a pillowcase.

(C) Toiletries shall include a towel, washcloth, toothbrush, toothpaste and soap.

(D) Bedding and sleeping apparel shall be laundered weekly and as needed.

(7) Sleep arrangements for infants shall comply with section 19a-79-10(g) of the Regulations of Connecticut State Agencies.

(8) The ambient air temperature shall be maintained to at least sixty-five (65) degrees Fahrenheit measured at thirty six (36) inches from the floor.

(9) There shall be written approval from the local fire marshal specifying the hours of operation.

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(10) There shall be written approval from the local health director for night care.

(Effective July 27, 1993; Amended November 6, 2008)

Sec. 19a-79-13. The monitoring of diabetes in child day care centers and group day care homes

(a) Policy and Procedures

(1) All child day care centers and group day care homes at which designated staff members will be administering finger stick blood glucose tests shall have written policies and procedures governing the administration of finger stick blood glucose tests to children diagnosed with diabetes mellitus. The policies and procedures shall address at least the following areas:

- (A) parental responsibilities;
- (B) staff training and responsibilities;
- (C) proper storage, maintenance and disposal of test materials and supplies;
- (D) record keeping;
- (E) reporting test results, incidents and emergencies to the child's parent(s) and the child's physician, physician assistant or advanced practice registered nurse; and
- (F) a location where the tests occur that is respectful of the child's privacy and safety needs.

(2) Said policies and procedures shall be available for review by the department during facility inspections or upon demand.

(b) Training

(1) Prior to the administration of finger stick blood glucose tests, the director, head teacher, program staff or group day care home provider shall have completed the following training requirements:

(A) a course approved by the department in first aid, as verified by a valid first aid certificate on file at the facility; and

(B) additional training given by a physician, physician assistant, advanced practice registered nurse, registered nurse, certified emergency medical technician or the child's parent(s) according to written guidelines provided by the child's physician, physician assistant or advanced practice registered nurse. The additional training shall include, but not be limited to:

- (i) the proper use, storage and maintenance of the child's individual monitoring equipment;
- (ii) reading and correctly interpreting test results; and
- (iii) appropriate actions to take when test results fail to fall within specified ranges indicated in the written order from the child's physician, physician assistant or advanced practice registered nurse.

(2) The training shall be updated at least every three years when a child with diabetes mellitus who requires finger stick blood glucose testing is present at the facility.

(3) Documentation that staff has been trained to administer finger stick blood glucose

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tests shall be in writing and kept at the facility for review by the department. Such documentation shall indicate:

- (A) the subjects covered in training;
- (B) the signature and title of the instructor;
- (C) the signature and title of the trainee; and
- (D) the date the training was given.

(c) Administration of Finger Stick Blood Glucose Test

(1) Except as provided in subdivision (3) of this subsection, only staff members trained in accordance with subsection (b) of this section may administer the finger stick blood glucose test in a child day care center or group day care home.

(2) Whenever a child diagnosed with diabetes mellitus who has orders to receive finger stick blood glucose monitoring is enrolled and present at the facility, a staff member designated and trained to administer finger stick blood glucose tests shall be present at the facility.

(3) Upon the written authorization of the child's physician, physician assistant or advanced practice registered nurse and the child's parent(s), a child may self administer the finger stick blood glucose test under the direct supervision of the designated staff member who has met the training requirements in subsection (b) of this section.

(4) The operator of a child day care center or group day care home may petition the department to permit staff to administer glucagon by injection, in emergency situations only, in accordance with section 19a-79-9a(b)(7) of the Regulations of Connecticut State Agencies.

(d) Equipment

(1) The child's parent(s) shall supply the operator with the necessary equipment and supplies to meet the child's individual needs.

(2) Such equipment and supplies shall be labeled with the child's name and shall remain inaccessible to other children when not in use.

(3) The operator shall obtain a signed agreement from the child's parent(s) that the parent(s) agrees to check and maintain the child's equipment in accordance with manufacturer's instructions, restocks supplies and removes material to be discarded from the facility on a daily basis. All materials to be discarded shall be kept locked until it is given to the child's parent(s) for disposal.

(e) Record Keeping

The operator shall keep the following records at the facility as part of the child's medical record, and shall update them annually or when there is any change in the information.

(1) A current, written order signed and dated by the child's physician, physician assistant or advanced practice registered nurse indicating:

- (A) the child's name;
- (B) the diagnosis of diabetes mellitus;
- (C) the type of blood glucose monitoring test required;
- (D) the test schedule;

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- (E) the target ranges for test results;
 - (F) specific actions to be taken and carbohydrates to be given when test results fall outside specified ranges;
 - (G) diet requirements and restrictions;
 - (H) any requirements for monitoring the child's recreational activities; and
 - (I) conditions requiring immediate notification of the child's parent(s), emergency contact, the child's physician, physician assistant or advanced practice registered nurse.
- (2) An authorization form signed by the child's parent(s) which includes the following information:
- (A) the child's name;
 - (B) the parent(s) name;
 - (C) the parent(s) address;
 - (D) the parent(s) telephone numbers at home and at work;
 - (E) two adult, emergency contact people including names, addresses and telephone numbers;
 - (F) the names of staff designated to administer finger stick blood glucose tests and provide care to the child during testing;
 - (G) additional comments relative to the care of the child, as needed;
 - (H) the signature of the parent(s);
 - (I) the date the authorization is signed; and
 - (J) the name, address and telephone number of the child's physician, physician assistant or advanced practice registered nurse.
- (3) The operator shall notify the child's parent(s) daily in writing of the results of all blood glucose tests and any action taken based on the test results, and shall document the test results and any action taken in the child's medical record.

(Adopted effective June 30, 1998; Amended November 6, 2008)

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Agency

Department of Public Health

Subject

Family Day Care Homes

Inclusive Sections

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Family Day Care Homes

Sec. 19a-87b-1. Purpose

The purpose of registration of family day care homes is to assure that family day care homes meet the health, educational and social needs of the children utilizing such homes.

(Effective September 1, 1993; Transferred January 29, 1996)

Sec. 19a-87b-2. Definitions

For the purpose of Sections 19a-87b-2 through 19a-87b-17 of the Regulations of Connecticut State Agencies, the following definitions shall apply:

(1) “Administration of Medication” means the direct application of a medication by inhalation, injection or any other means to the body of a person.

(2) “Adult” means a person eighteen (18) years of age or over.

(3) “Advanced practice registered nurse” means an individual licensed pursuant to subsection (b) of section 20-94a of the Connecticut General Statutes.

(4) “Applicant” means a person, twenty (20) years of age or older, who has completed, signed and submitted an application to the department to obtain a family day care home registration.

(5) “Application” means the forms prescribed by the Commissioner which are to be used by applicants for initial registration, by providers for registration renewal, and by family day care staff for staff approval. Forms may be changed by the Department from time to time.

(6) “Assistant” means an adult approved in writing by the Commissioner, who assists the provider or substitute in caring for children in the registered facility, while the provider or substitute is present.

(7) “Authorized prescriber” means a physician, dentist, advanced practice registered nurse or physician assistant.

(8) “Child” means any person under eighteen (18) years of age.

(9) “Commissioner” means the Commissioner of the Department of Public Health or the commissioner’s designee(s) or representative(s).

(10) “Customary Business Hours” means the hours in which the family day care home is in operation caring for children.

(11) “Department” means the Department of Public Health.

(12) “Emergency Caregiver” means a person twenty (20) years of age or older, who can assume the provider’s duties in an unforeseen emergency situation.

(13) “Facility” means the entire premises, identified on the registration application, indoors and outdoors, including space not directly used for child care.

(14) “Family Day Care Home” means a facility so designated under Connecticut General Statute 19a-77 as same may be amended.

(15) “Family Day Care Services” means care of not more than six children, including provider’s own children not in school full time, where the children are cared for not less than three nor more than twelve hours during a twenty-four-hour period and where care is

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given on a regularly recurring basis. During the regular school year, a maximum of three additional children who are in school full time, including the provider's own children, shall be permitted, except that if the provider has more than three children who are in school full time, all of the provider's children shall be permitted.

(16) "Investigational drug" means any medication with an approved investigation new drug application on file with the Federal Food and Drug Administration (FDA), that is being scientifically tested and clinically evaluated to determine its efficacy, safety, and side effects and that has not yet received FDA approval.

(17) "Home Visit" means a visit to the family day care home of an applicant or provider by department staff. Said home visit may be announced, as when the initial application inspection is performed; or unannounced, when performed in response to a complaint or as a spot inspection. All home visits shall be performed during customary business hours.

(18) "Household member" means any person other than the provider who resides in or has a right to reside in the family day care home, such as the provider's spouse or children, boarders, and any other occupant.

(19) "Medication" means any medicinal preparation including controlled substances, as defined in section 21a-240 of the Connecticut General Statutes.

(20) "Medication error" means failure to administer the medication to a child, or failure to administer medication within one (1) hour of the time designated by the prescribing practitioner, or failure to administer the specific medication prescribed for a child, or failure to administer the medication by the correct route or failure to administer the medication according to generally accepted medical practices, or failure to administer the correct dosage of medication.

(21) "Night Care" means family day care services provided during a child's normal night time sleeping hours.

(22) "Parent" means the person who retains custody of the child; i.e. the mother, father, supervising relative, legal guardian or foster parent.

(23) "Physician" means a doctor of medicine or osteopathy licensed to practice medicine in this or another state.

(24) "Physician assistant" means an individual licensed pursuant to section 20-12b of the Connecticut General Statutes.

(25) "Primary health care provider" means the individual who is responsible for the health care of the child outside the facility.

(26) "Provider" means the person registered by the department to provide family day care services, and who may substitute for another registered provider.

(27) "Registered Capacity" means the number of day care children that the provider is authorized to care for as contained in the registration certificate.

(28) "Registered nurse" means a person with a license to practice as a registered nurse in connecticut in accordance with chapter 378 of the Connecticut General Statutes.

(29) "Registration" means the official process by which an applicant has been given a license granting legal permission by the Commissioner to operate a family day care home.

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(30) “Residence” means a home occupied by the provider or approved for occupancy as a home as evidenced by a valid certificate of occupancy.

(31) “Substitute” means a person approved in writing by the Commissioner who may assume the provider’s responsibilities in the provider’s absence, and who meets the same qualifications as a provider.

(Effective September 1, 1993; Amended August 8, 1995; Transferred January 29, 1996; Amended November 3, 1997)

Sec. 19a-87b-3. Application for a registration to operate a family day care home

(a) Registration Required to Operate

No person, group of persons, association, organization, corporation, institution or agency, public or private, may operate a family day care home in the State of Connecticut without a registration issued by the Commissioner. Only one registration shall be issued per residence.

(b) Relative Providers who are Required to Register

An individual who provides child care at a home other than the child’s own for children who are not his/her grandchild(ren), niece(s), nephews(s), sibling(s), son(s) or daughter(s) by blood, adoption or marriage is required to register. The Department may require documentation verifying the relationship.

(c) Application Form

A person may apply for a family day care home registration by completing, signing and submitting to the Department an application to obtain a family day care home registration. Only one registration shall be issued per residence. The application forms are available through any office of the Department. The application forms, which may be modified by the Commissioner from time to time, shall contain information that the Commissioner deems necessary to determine whether the applicant or provider shall be issued or re-issued a family day care home registration. The application forms shall contain a notice that false statements made therein are punishable in accordance with Section 53a-157 of the Connecticut General Statutes, and that false statements may also be grounds for the denial of the registration. The application forms shall contain a certification that the applicant or provider is familiar with the family day care home regulations, agrees to abide by them, and will allow home visits by Department staff to the family day care home.

(d) Release Forms

The applicant, household members, and proposed family day care staff, as part of the application process, shall also agree to provide and/or authorize Department access to any information or records that the Commissioner deems necessary to investigate and/or verify that the applicant meets the requirements of Section 19a-87b-6 through 19a-87b-8 of the Regulations of Connecticut State Agencies, inclusive, including, but not limited to, medical information, police records and records of the Department of Children and Families.

If the applicant, household members and proposed day care staff refuse to cooperate with the Department in completing this process, or fail to provide the required information, such

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failure shall constitute sufficient reason for denial of the application.

(e) Interview and Inspection

The applicant shall be interviewed as part of the application process, and shall allow Department personnel to inspect thoroughly the entire premises.

(f) Denial of Application - Request for a Fair Hearing

An applicant who is aggrieved by the Department's denial of his/her application for family day care home registration may submit to the Commissioner a written request for a fair hearing on the denial, which shall state in simple language the reasons why the aggrieved person is seeking to have the denial reviewed by the Department. The request for a fair hearing shall be mailed to the Commissioner within sixty (60) days from the date of the denial letter.

(g) Reapplication Process

A provider who has voluntarily withdrawn or terminated an application or registration may reapply by filing a new application with the Department at any time.

(Effective September 1, 1993; Amended August 8, 1995; Transferred January 29, 1996)

Sec. 19a-87b-4. Renewal of registration

(a) Renewal Application

A registered provider of family day care home services who desires to renew a registration shall submit before the expiration date an unaltered, completed and signed application for renewal on the forms prescribed by the Commissioner. Information requested at renewal includes, but is not limited to:

- (1) Current enrollment
- (2) A statement that all children in facility are up to date on immunizations
- (3) Information on staff
- (4) Statement of change in any household member's health status
- (5) Physical changes made to the facility
- (6) Changes in family situation
- (7) Statement of compliance with the regulations for family day care homes.

(b) Registration to Remain in Effect

In the event that an unaltered, completed and signed application for a renewal of a registration to operate a family day care home has been submitted in a timely manner to the Department, but has not been acted upon by the Commissioner before the expiration date, the registration shall remain in effect until the Commissioner makes his decision on such application. During this period, all laws and regulations, as amended, governing the operation of a day care home shall remain in effect and be binding upon the provider.

(Effective September 1, 1993; Transferred January 29, 1996)

Sec. 19a-87b-5. Terms of the registration

(a) Registration Term and Fee

The registration shall be for a term of one year from the date of issuance and the

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Commissioner shall collect a fee of ten dollars for such registration from the applicant or provider. Only one registration at a time shall be issued per residence.

(b) Suitability

A registration will not be issued to any applicant, or renewed for a provider, unless the Commissioner finds that such applicant or provider is a suitable person to care for children in a family day care home and meets and agrees to comply with Sections 19a-87b-1 to 19a-87b-16 inclusive of these regulations. Suitability shall be determined by a review of the application materials, references, any criminal records, law enforcement records, medical records, protective services records and any other relevant material obtained by the Department. The Commissioner shall, after reviewing all the circumstances, make a determination whether the applicant or provider is a suitable person to care for children in a family day care home and whether the children's health and safety would be at risk under said applicant or provider's care.

(c) Nontransferability of the Registration

An applicant may apply for a registration only in his/her own name and only for the premises indicated on the application, which premises shall be a residence.

(1) A registration shall not be assigned by a provider to any other person under any circumstances. A provider shall not use a substitute on a regularly, recurring basis which effectively franchises or transfers the family day care services to the substitute.

(2) When the provider moves the family day care home to another facility, the old registration is no longer valid as issued. A new application to change the address shall be filed with the Department immediately. No fee is charged for this application, but a home visit is required to operate. The provider must notify the Department immediately to schedule a home visit.

(d) Factors in Determining the Registered Capacity

(1) The registered capacity of the facility shall be indicated by two (2) numbers on the registration certificate:

(A) Regular capacity defines the maximum number of infants, toddlers, preschoolers, kindergarten and school age children that a provider may care for together at any time during the year, including the provider's own children not in school full time. School age children who are not the provider's own children and receive family day care services for three (3) or more hours before school or three (3) or more hours after school shall be counted in the regular capacity. The regular capacity of a family day care home shall not exceed six (6) children.

(B) School age capacity defines the maximum number of additional children attending school full time that a provider may care for together before and after school during the school year only, including the provider's own school age children. The school age capacity shall not apply during the summer school vacation; however, the provider's own school age children shall be permitted without counting them in the regular capacity. The school age capacity of a family day care home shall not exceed three (3) children.

(2) Children attending full day kindergarten shall be counted in the school age capacity;

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children attending half day kindergarten shall be counted as preschoolers in the regular capacity until graduation from kindergarten.

(3) Staff members' children present at the facility shall be counted in the capacity like the other children receiving care.

(4) Foster children and children who reside at the facility shall be counted as household members in the same manner as the provider's own children.

(5) The provider's own children twelve (12) years of age and older shall not count in the capacity.

(6) The registered capacity shall be determined at the Commissioner's discretion taking into account the indoor and outdoor space and other accommodations available for child care at the facility and the qualifications of the applicant or provider.

(e) Infant and Toddler Restriction

The provider shall care for no more than two (2) children under the age of two (2) years at one time, including his/her own children, except that the provider may care for up to six (6) children under the age of two (2) years when an assistant is present.

(f) Variance of Requirements

A family day care home and provider shall comply with all family day care regulations unless a variance for specific requirement(s) has been granted through a prior written agreement with the Commissioner. This agreement shall specify the particular requirement(s) affected, the duration of the variance, and the terms under which the variance is granted. Variance of specific requirements shall be granted only when the home and provider have documented that the intent of the specific requirement(s) affected will be satisfactorily achieved in a manner other than that prescribed by the requirement(s). A variance shall not be given to allow a provider to care for more children than indicated by the registered capacity. When the home or provider fail to comply with the variance agreement in any particular, the agreement shall be subject to immediate cancellation.

(g) Registration Certificate

Upon approval of the initial application and or renewal application, and payment of the fee, a registration certificate shall be signed by the Commissioner and issued to the provider. The registration certificate shall identify the provider's name, the address of the facility, the registered capacity of the family day care home, the registration number and the expiration date.

(1) The registration certificate remains the property of the Department and shall be surrendered to the Commissioner if the registration is suspended, revoked, or voluntarily terminated.

(2) The registration certificate shall be displayed conspicuously in a location visible to the Department Staff and to parents whose children are in care or who are considering placing their children in the provider's care.

(3) The registration number shall be used in any advertisement of services.

(h) Parental Access to the Department

When a child is enrolled, the provider shall furnish the parent(s) with the telephone

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number of the local office of the Department. The provider shall explain that any person with good cause and in good faith may file a complaint about a registered or unregistered provider with the Department.

(i) Consent to Home Visits

The provider and substitute shall consent in writing and agree to allow Department staff to inspect the facility and have access to day care records for the performance of home visits during customary business hours.

(j) Notification of Change

The applicant or provider shall notify the Commissioner in writing within five (5) working days of any change in circumstances which alters or affects the day care service as registered or as stated in the application. Changes of circumstances which shall be reported include, but are not limited to, the following: change of address, renovation of facility, the addition of household members, or changes in the health status of the provider, staff, or household members that may affect the provision of family day care services.

(Effective September 1, 1993; Transferred January 29, 1996)

Sec. 19a-87b-6. Qualifications of the applicant and provider

(a) Awareness of Regulations

The applicant and provider shall have a copy of the regulations at the facility and shall have read and understood the family day care standards set forth in these regulations.

(b) Health

The applicant and provider shall be physically, emotionally and mentally able to handle child care responsibilities and emergencies and shall be free from any mental, emotional or physical health problems which might impair such ability or otherwise adversely affect the day care children. In order to enable the Commissioner to determine that the provider meets these requirements, the following shall be provided upon request:

(1) Medical Statements

The applicant shall furnish, at the time of initial application, a medical statement signed by a physician, physician assistant or advanced practice registered nurse based on an examination conducted within the past twelve (12) months, documenting the presence of any known medical or emotional illness or disorder that would currently pose a risk to children in care or would currently interfere with effective functioning as a provider. Thereafter, the provider shall submit a medical statement, described above, every two (2) years and at any other time requested by the Commissioner.

(2) Tuberculosis

The applicant shall furnish a negative skin test for tuberculosis or, for a known reactor, evidence of no active tuberculosis on a chest x-ray, based on a test or x-ray given during the past twelve (12) months, and thereafter upon the request of the Commissioner.

(3) Medical Records

The applicant and provider shall supply to the Commissioner on request any medical records regarding his/her physical, emotional or mental health. The applicant and provider

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shall execute a release authorizing access to his/her medical records upon request of the Commissioner when the Commissioner deems the applicant or provider's medical history may reveal a risk to children in care.

(4) Medications

At the Commissioner's request the applicant and provider shall furnish information and/or shall supply or authorize the release of medical records regarding any ongoing medications being used by the applicant or provider.

(c) **Trainings Requirements**

(1) Any application for registration submitted to the Department on or after January 1, 1994 shall, before final approval of the application is given, include a copy of a valid certificate from an approved course in basic first aid appropriate for child care providers.

(2) Providers registered prior to January 1, 1994 shall furnish to the Department a copy of a valid certificate documenting successful completion of such training by September 1, 1994.

(3) Thereafter, as part of the renewal application, the provider shall furnish a copy of a valid certificate of such training to the Department as necessary to verify continuous certification.

(4) The Department shall approve a course in basic first aid if it meets the standards set for Group Homes and Day Care Centers as specified in the Child Day Care Unit Policy Manual of the Department of Health Services.

(d) **References**

The applicant shall submit at least three (3) reliable and satisfactory references from individuals who have known the applicant for at least three (3) years. The references shall indicate the applicant's interest in, and affection for children, their understanding of children's developmental needs, good judgment about supervision and safety for children, personal competence, emotional stability and dependability. Only one reference may be from a person related to the applicant by blood or marriage. The Commissioner may request additional references as needed to verify continuing compliance with the regulations during the registration period.

(e) **Personal Qualities**

The applicant and provider shall have the personal qualities appropriate for working and communicating with children and their families. The Commissioner will review all application materials, personal references, medical records, criminal records and Department of Children and Families records submitted on an applicant and provider to determine if he/she has an interest in and liking for children, understanding of children and their developmental needs, good judgement about supervision and safety for children, personal competence, emotional stability and dependability. Suitability shall also be determined from a review of any complaint investigation and any law enforcement or protective services records.

(f) **Criminal Record Check**

National, state and local police records shall be checked by the department. The applicant,

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provider, or any person working in the family day care home shall not have a criminal record that the Commissioner reasonably believes renders such applicant, provider, assistant or substitute unsuitable to own, conduct, operate, or maintain or be employed by a family day care home.

(g) Protective Services Check

(1) The applicant and provider shall be checked with the Department of Children and Families to determine whether:

(A) There is a Department of Children and Families record of child abuse, neglect or risk thereof, or whether there is an ongoing investigation for such offenses.

(B) A child has been removed from care or custody for reasons of abuse, neglect or risk thereof.

(2) A finding that there is a Department of Children and Families record or an on-going Department of Children and Families investigation or that a child has been removed from care or custody, as set forth in subdivision (1) of this subsection (h), shall provide a sufficient basis for the Commissioner to take immediate action against the registration. The Commissioner may deny a day care application, summarily suspend and/or propose to revoke a registration, or immediately revoke permission for a family day care home staff member to provide care under this section, depending on the particular circumstances of a given case.

(3) In keeping with the confidentiality provisions of Section 17a-101 of the Connecticut General Statutes, the Department will hold confidential information obtained under this section.

(h) Offenses or Information from Other Jurisdictions

The Commissioner may request that a screening for child abuse, neglect, or criminal conviction records be done in another state as necessary to ensure the applicant or provider's background does not present a risk to children. If the Commissioner obtains information of conduct in another jurisdiction by an applicant or provider that would have resulted in a denial of a family day care home registration to such an applicant or provider if such conviction or conduct had occurred in this state, it may be grounds for denial or suspension or revocation of such a registration.

(Effective September 1, 1993; Amended August 8, 1995; Transferred January 29, 1996; Amended June 4, 1999)

Sec. 19a-87b-7. Members of the household

(a) Health

The members of the household shall be free from any mental, emotional or physical health problems which might adversely affect the day care children. The following documentation shall be part of the initial application process and updated as deemed necessary by the Commissioner:

(1) Medical statements and children's immunization records

A medical statement signed by a physician, physician assistant or advanced practice

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registered nurse, based on an examination conducted within the past twelve (12) months. The statement shall document, for each household member, the presence of any known medical or emotional illness or disorder that would currently pose a risk to children in care or would currently interfere with, or otherwise put in jeopardy, the provider's ability to render proper care to the day care children in the day care facility. All adult members of the household shall furnish a negative skin test for tuberculosis or, for a known reactor, no evidence of active tuberculosis on a chest x-ray, based on a test or x-ray given during the past twelve (12) months, and thereafter upon request of the Commissioner. The provider shall maintain forms for each child in the household including the provider's own children present at the facility as specified in subdivisions (2) and (3) of subsection (b) of section 19a-87b-10. The forms shall also state that the child is current with all required immunizations and shall indicate the date for the next scheduled immunization.

(2) Medical and medication records

A medical history and medication records for each member of the household, if requested by the Commissioner, or authorizations from such members allowing the release of these records, when the Commissioner deems the household member's medical history may reveal a risk to children in care.

(b) **Criminal record check**

The members of the household in a family day care home shall not have been convicted of any offenses which the Commissioner reasonably believes renders such household unsuitable for the provision of family day care services, including but not limited to:

- (1) Cruelty to persons under Section 53-20 of the Connecticut General Statutes.
- (2) Injury or risk of injury to or impairing morals of children under Section 53-21.
- (3) Abandonment of children under the age of six (6) years under Section 53-23.
- (4) Sexual assault in the fourth degree under Section 53a-73a, as same may be amended.
- (5) Illegal manufacture, distribution, sale, prescription, dispensing or administration of controlled substances under Section 21a-277, 21a-278 or 21a-278a.
- (6) Illegal possession under Section 21a-279, as same may be amended.

(c) **Protective Services Check**

All members of the household shall meet the same standards as required for the provider by Section 19a-87b-6 (h).

(d) **Offenses or Information from other Jurisdictions**

All members of the household shall meet the same standards as required for the provider by Section 19a-87b-6 (i).

(e) **Household Environment**

The environment in the household shall foster the health, growth and development of children. Evidence of violent or threatening behavior by household members will be reviewed by the Commissioner for its impact on the health and safety of the day care children and may be grounds for denial, suspension, or revocation of the registration.

(Effective September 1, 1993; Amended August 8, 1995; Transferred January 29, 1996)

Sec. 19a-87b-8. Qualifications of staff

The provider may have substitutes and assistants in the facility only after the intended staff member has submitted a staff approval application to the Department and it has been approved in writing by the Commissioner.

(a) Substitute

Any person twenty (20) years of age or older who meets all of the requirements set forth in Section 19a-87b-6, “Qualifications of the Applicant and Provider,” may apply to be a substitute for a family day care provider. A registered provider may substitute for another provider without filing a separate staff approval application.

(b) Assistant

Any adult who meets the requirements set forth in Section 19a-87b-6, “Qualifications of the Applicant and Provider,” except for subsection (a) pertaining to age and (d) pertaining to training, may apply to be an assistant in a family day care home. An assistant is required to be present when more than two (2) children under (2) years of age receive family day care services at the same time at the facility.

(c) Emergency Caregiver

Each provider shall identify to the Department at least one emergency caregiver who shall be available and on call during customary business hours to provide child care only for unscheduled, unforeseen emergencies.

(1) The emergency caregiver shall be a responsible person who is twenty (20) years of age or older and known to the provider. The provider shall list at least one potential emergency provider with the Department, but may use others as necessary.

(2) The emergency caregiver shall be able to arrive at the facility within ten (10) minutes of being summoned by the provider.

(3) The Commissioner may disallow any emergency caregiver who had a family day care home registration revoked or denied, or who has a substantiated child abuse/neglect or a criminal conviction record that the Commissioner deems would put children at risk.

(d) Knowledge of Regulations and Operative Procedures

All staff members shall have read and understood the regulations for family day care homes and shall be familiar with the operating procedures of the facility.

(e) Staff Approval Process

Staff approvals for substitutes, assistants, and helpers shall be for a period of two (2) years from the date of the approved staff application. Approvals may be renewed by submitting to the Department a new staff renewal application and a new medical statement as described in Section 19a-87b-6 subsection (c) for substitutes and assistants, and in Section 19a-87b-10 subsection (2) for helpers. Emergency providers may remain on call as long as they continue to meet the requirements of that position. The Commissioner may at any time deny or revoke the approval of any staff member who fails to meet the requirements of the position.

(Effective September 1, 1993; Transferred January 29, 1996)

Sec. 19a-87b-9. Requirements for the physical environment

(a) Cleanliness

The facility and equipment shall be kept in a clean and sanitary condition and shall not pose a health hazard to children. The Commissioner, upon inspection, may require the provider to correct any condition that may put children at risk of injury.

(b) Freedom from Hazards

The facility and equipment shall be in good repair, and reasonably free from anything that would be dangerous to children. The Commissioner, upon inspection, may require the provider to correct any condition that may put children at risk of injury.

(c) Absence of poisonous substances

Poisonous substances shall not be accessible to children enrolled in the facility. Poisonous and unidentified plants and plant parts shall be removed from the area, protected by barriers, or kept out of the reach of children.

(d) Fire Safety

The provider shall ensure that the home and grounds provide a reasonable degree of safety from fire, which shall include, but not be limited to the following requirements:

(1) Safe Storage of Flammable Materials

Materials such as, but not limited to, flammable or combustable liquids, cleaning solvents, paints, excess amounts of combustable solids and fabrics shall be properly stored and out of reach of children.

(2) Safe Door Fasteners

Fasteners for doors to cupboards, closets and rooms shall be designed so that it is impossible for a child to become locked in the enclosed area.

Every room used for child care or capable of access by children, when provided with a door latch or lock, shall be of a type that children can open from the inside and each lock shall be designed to permit opening of the locked door from the outside in an emergency. The opening device shall be readily accessible to the provider and staff.

(3) Electrical Safety

Electrical cords and appliances shall be in good repair.

Special protective covers for all electrical receptacles shall be installed in all areas occupied by children.

(4) Safe Exits

There shall be two (2) readily accessible, passable, remotely located and safe means of escape from each room used for day care in the facility.

Every room used by children for sleeping, living, or dining purposes shall have at least two (2) means of escape, at least one of which shall be a door or stairway providing a means of unobstructed travel to the outside of the building at street or ground level.

The second means of escape shall be permitted to be a window that is accessible and openable from the inside without the use of tools and provides a clear opening.

(A) The provider shall remain with the children at all times, when the children are being cared for in space below ground level, to assist with emergency exiting.

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(B) Passageways leading to means of escape shall have adequate lighting and be kept free from barriers or obstructions.

(C) All means of escape shall be easily opened and kept free of obstructions at all times.

(D) Every stairway shall have a sturdy handrail for children to use, shall provide safe passageway and be maintained free of obstructions. Sturdy child-safe gates shall be placed at the top and bottom of stairways to prevent falls.

(E) During a home visit Department Staff may require the provider to demonstrate the safety and feasibility of children and child care staff using intended escape routes.

(5) Evacuation Plan

The provider shall establish a written plan for the protection of occupants in the event of fire or other emergency evacuation from the building. All child care staff shall be periodically instructed and kept informed of their duties under the plan and shall practice at least quarterly an emergency evacuation drill.

(6) Smoke Detectors

The provider shall have smoke detectors, in operating condition, placed in the home so as to protect day care children's sleeping areas, play areas and the basement. There shall be at least one smoke detector on each level of the facility.

(7) Fire Extinguisher

(A) The provider shall have easily accessible to the area of child care at least one five (5) pound ABC multi-purpose fire extinguisher in operating condition and shall have knowledge of its use.

(B) Each fire extinguisher shall be installed using the hanger or brackets supplied, at a height not to exceed five (5) feet above the floor. Extinguishers shall not be obstructed or obscured from view.

(8) Safe Heating Systems and Devices

(A) The provider shall show documentation that any new heating system or auxiliary heater installed after original construction of the facility has been inspected and approved for proper and safe installation by an authorized licensed professional and, where applicable the local building official. All devices shall be safely located, shall be properly cleaned and maintained with a barrier where necessary for the protection of day care children.

(B) There shall be no kerosene heaters or unsafe space heaters used during the hours of day care.

(e) **Safe Storage of Guns, Ammunition and other Weapons**

The provider shall protect children from guns, ammunition and weapons stored at the facility.

(1) All guns shall be stored unloaded.

(2) Ammunition shall be stored in a separate location away from the guns and inaccessible to children.

(3) All guns and weapons shall be kept locked or stored in a locked storage area. Locks shall be openable with a key or combination only.

(f) **Safe Space**

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(1) There shall be sufficient indoor and outdoor play space to ensure appropriate activities, safety and comfort for the day care children. The indoor and outdoor play space shall be neither isolated nor remote from the primary care areas. The outdoor play area shall be protected from traffic, bodies of water, gullies, and other hazards by barriers, in a manner safe for children.

(2) When there is a swimming pool or any other body of water at the facility or near enough to the facility to attract or be accessible to children at any time of the year, there shall be a sturdy fence/barrier, four (4) feet high or higher, with locked entrances, which totally and effectively bars access to the water by the day care children. Shallow wading pools that are not fenced shall be emptied after each use and shall not collect water.

(g) Proper Ventilation, Light and Temperature

The ventilation, light and temperature of the facility shall ensure the health and comfort of the day care children. The room temperature where children are present at the facility shall not be lower than 68 degrees Fahrenheit.

(h) Adequate Washing, Toileting, Sewage and Garbage Facilities

The bathroom washing and toileting facilities shall be adequate to ensure the health, safety and comfort of the day care children. Sewage and garbage disposal systems shall ensure a sanitary environment. Garbage and trash shall be disposed of properly and kept covered.

(i) Adequate and Safe Water

If the facility is not served by a public water supply, the provider shall show proof from analysis by a state certified laboratory dated no more than one year prior to the application date at initial registration and as often as the Department deems necessary, that its water supply is potable, adequate, and safe. The water test shall include, but not be limited to tests for bacteria, physical parameters (color, odor, turbidity, pH), and sanitary chemicals (nitrogen series, chloride, surfactants, hardness, iron, manganese and sodium). Additional tests may be required as deemed necessary by the Commissioner.

(j) Pasteurization or Licensed Milk Supply

If milk or milk products provided by the family day care home provider for consumption by the children in care are not pasteurized, the provider shall submit to the Department proof that the milk products are licensed by the Department of Agriculture.

(k) Working Telephone

The provider shall have a working telephone at the facility, with emergency numbers (fire, ambulance, police or 911, parents, emergency caregivers, and poison control) posted nearby in an easily visible location.

(l) Safe Transportation

The provider shall utilize safe transportation for children when transportation is required for an emergency or a day care activity. This shall include, but not be limited to, the use of child auto safety restraints according to Section 14-100a (c) of the Connecticut General Statutes. Any vehicles used to transport day care children shall be properly registered and insured.

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(m) First Aid Supplies

The provider shall have easily available, but out of reach of young children, adequate first aid supplies and current information about medical emergencies and appropriate first aid procedures.

(n) Protection from Pets

The provider shall be responsible for protecting the health and safety of the children from household pets and other animals at the facility. A current rabies vaccination certificate shall be kept on file at the facility for each dog and cat over fourteen (14) weeks of age. The provider shall be responsible for maintaining household pets in accordance with all applicable local and state laws and to have such documentation on file. The Commissioner has the discretion to deny, suspend or revoke a registration if he deems that the type, number or condition of the pets at the facility presents a health or safety hazard to children.

(o) Smoking

The provider shall protect children from hazards associated with tobacco use in the facility.

(1) If the provider, household members, or staff members smoke cigarettes, cigars, or pipes, the provider shall make this known in advance to parents who are considering placing their children in the provider's care.

(2) The provider or staff members may not smoke while engaged in caregiving activities requiring direct physical contact with children, including, but not limited to feeding, diapering, dressing and rocking.

(3) The provider shall ensure that all cigarettes, cigars, pipes, ashes, butts, lighters and matches are kept out of the reach of children.

(Effective September 1, 1993; Transferred January 29, 1996)

Sec. 19a-87b-10. Responsibilities of the provider and substitute

(a) Registered Capacity and Maintaining Compliance with the Regulations

The provider shall maintain the family day care home within the registered capacity, and in compliance with the regulations for family day care.

(b) Maintaining records on children

The provider shall maintain the following records for each child enrolled in day care, or who has been in day care at the facility, and shall keep them current and available in the facility. Forms may be obtained from the Department.

(1) Enrollment Form

The provider shall have on file an enrollment form including the schedule of days and hours of care, the parent's name, address, telephone numbers and the child's date of birth and date of enrollment at the facility. This form shall be kept for one year after a child ceases to be cared for in the facility.

(2) General health record

(A) The provider shall have a complete and current general health record on file when the child begins attending the family day care home, signed and dated by a physician,

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physician assistant or advanced practice registered nurse, based on an examination within the past year for preschoolers or within the period allowed by schools for older children. A complete and current general health record shall include but not be limited to, the following information pertaining to the child:

(i) A statement about the child's general health and the presence of any known medical or emotional illness or disorder that would currently pose a risk to other children in care or which would currently affect the child's functional ability to participate safely in a day care setting.

(ii) Allergies.

(iii) Disabilities.

(iv) Ongoing medications.

(v) An immunization record that includes the month, day, and year of each immunization required for admission as specified in subdivision (1) of subsection (k) of this section, and such documentation as is required to confirm age appropriate immunization, immunization in progress or exemption to immunization as defined in subdivision (3) of subsection (k) of this section. The immunization record and said documentation of immunizations shall be submitted to the department upon request.

(B) Medical records for infants/toddlers and preschoolers shall be updated at least annually, and for school age children according to the schedule required by the public school system.

(C) These records shall be returned to the parent when the child is withdrawn from the family day care home.

(D) The physical examination requirements of this subdivision shall be waived when such examination is contrary to the religious beliefs and practices of the child or the parents of such child. A statement requesting such waiver shall be submitted and shall be maintained in the child's general health record. Such statement shall be signed by the parent and shall include affirmation of church membership by an appropriate church authority. The parent shall certify that he or she accepts complete responsibility for the health of the child and that, to the best of the parent's knowledge, the child is in good health.

(3) Written Permission from the Parent

The provider shall have on file and shall keep updated the parent's written permission and instructions specifying, but not limited to, the following:

(A) Any persons permitted to remove the child from the day care home on behalf of the parent.

(B) Emergency health care for the child, including information about the child's dentist, physician or other primary health care provider, and adults to be contacted if the parent cannot be reached.

(C) Transportation for children leaving the home as part of the day care program.

(D) The conditions under which the parent will allow swimming when recreational swimming is part of the family day care program.

(4) Incident Log

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The provider shall have on file an incident log for each enrolled child to record accidents, illnesses, unusual behaviors that occur at the facility and observations of the child made by the provider.

(5) Confidentiality of Records

The provider and day care staff shall not release any records pertaining to the child or family except in emergencies, or upon request of the Department, police, or Department of Children and Families, unless the parent of the child gives the provider and staff written permission to release this information.

(c) **Meeting Children's Physical Needs**

The provider is responsible for seeing that the day care children's physical needs are adequately met while in the facility including the following:

(1) Sufficient Play Equipment

There shall be a sufficient quantity and variety of indoor and outdoor equipment which is appropriate to the needs of the children, their developmental levels and interests. There shall be equipment which encourages large and fine muscle activity, solitary and group play and quiet play.

(2) Good Nutrition

The family day care program shall include adequate and nutritious meals and snacks, prepared and stored in a safe and sanitary manner including proper refrigeration for perishable foods. Readily available drinking water shall be accessible to children at all times.

(3) Flexible and Balanced Schedule

The schedule shall remain flexible, with time for free choice play, snacks, meals and a rest period.

(4) Proper Rest

There shall be a bed, cot, mat or other provision for each child for napping or resting which is comfortable, clean, safe, and allows for minimal disturbance for each day care child. Day care children shall not be napped directly on carpeting or flooring.

(5) Personal Articles

For each day care child, there shall be an individual blanket, towel and toilet articles appropriate to the needs of the child.

(d) **Individual Plan for Care**

The provider shall establish a planned program of developmentally appropriate activities at the facility, which promotes the social, intellectual, emotional and physical development of each child.

(1) The provider shall have an understanding and respect for the needs of children and their families who are bilingual and/or whose culture may differ from their own.

(2) The provider shall have an understanding of the special needs of children with disabilities receiving family day care services.

(3) An appropriate plan for each child's care shall be developed with the child's parent(s) at intake and updated as necessary to meet the child's changing needs.

(e) **Planning for the Special Needs of Infants**

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The provider shall allow infants to crawl or toddle, shall hold them for bottle feedings and at other times during the child care period, and shall give them individual attention, and verbal communication.

(f) Diaper Changing

The provider shall change an infant's diapers frequently for the child's comfort, shall cleanse and disinfect the surface of the changing area after changing each diaper, shall dispose of waste material in a sanitary manner out of reach of the children, and shall wash his/her own hands with soap and hot water after changing and disposing of each diaper.

(g) Giving Parents Information and Access

The provider shall furnish each child's parent(s) with the following:

(1) Opportunities to observe the day care home in operation prior to enrollment, as well as following enrollment.

(2) Immediate access to their child while the child is at the facility.

(3) Opportunities prior to enrollment as well as following enrollment to discuss the child's needs and the family day care program and policies, including the type of records the provider is required to keep and registered capacity.

(4) Daily information about the child.

(5) Immediate information about any accident involving the child, or any illness or injury to the child which occurred at, or was detected in, the day care home.

(6) Information about the names of substitutes, assistants, helpers, emergency providers and household members who have contact with the day care children.

(7) Information about the presence of enrolled children, or children of the provider, who are not properly immunized and any contagious illness affecting children, staff or household members at the facility, that could pose a health hazard to day care children.

(8) The provider shall allow the parents of all children receiving family day care services or wishing to place a child in the facility to see the provider's copy of the last interview/home visit report completed by Department Staff upon request.

(h) Supervision

The provider shall be responsible for the supervision of the children at all times while the children are at the facility, indoors or outdoors or on excursions. Supervision means guidance of the children's behavior and activities to insure their health, safety, and well being. It is done by a provider who is within effective sight or sound of the children.

(1) Personal Schedule

The provider's personal schedule shall ensure that the provider has sufficient rest for alert and competent attention to the children at the facility.

(2) Full Attention

The provider shall not engage in any activity while on duty during customary business hours that distracts his/her attention from providing family day care services. Such activities shall include but not be limited to other employment, volunteer services, recreation, hobbies, or frequent or prolonged socialization with adults.

(3) Immediate Attention

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The provider shall give an injured, ill, or distressed child immediate appropriate attention.

(4) **Substitute Care**

The provider shall not leave the presence of the day care children unless and until the substitute or emergency provider has assumed the provider's responsibilities and is actually present with the day care children.

(i) **Appropriate Discipline Practices**

The provider is responsible for the behavior management methods used in the family day care home and shall communicate them to staff members.

(1) The provider shall use only developmentally appropriate behavior management methods such as positive guidance, redirection, and setting clear limits that encourage children to develop self-control, self-discipline, and positive self-esteem, while also protecting them from harm to themselves or others.

(2) The provider shall discuss behavior management methods used in the facility with the child's parents prior to enrollment and regularly during the period a child remains enrolled.

(j) **Child Protection**

(1) The provider shall not engage in, nor allow, abusive, neglectful, physical, corporal, humiliating or frightening treatment or punishment, and shall not tie nor bind children and shall not restrain children except in appropriate circumstances for the protection and safety of the children or others. The provider shall not engage in nor allow anyone else to engage in any sexual activity with the day care children.

(2) The provider or substitute shall notify the Department within twenty-four (24) hours of:

(A) The death of any child enrolled in the family day care home, if the child died while at the facility or if the child died of a contagious disease.

(B) Any injury to a child that occurs while the child is at the facility which results in the child being admitted to a hospital or the child's death.

(3) The provider shall report actual or suspected child abuse or neglect of any child to the nearest office of the Department of Children and Families as mandated by Section 17a-101 and 17a-102 of the Connecticut General Statutes. An oral report shall be made immediately by telephone or otherwise to the State Commissioner of the Department of Children and Families or his representative, or the local police department, or the state police, to be followed by a written report as required by law.

(k) **Immunization requirements**

(1) A child seeking admission to or attending a family day care home shall be protected as age-appropriate by adequate immunization against diphtheria, pertussis, tetanus, poliomyelitis, measles, mumps, rubella, hemophilus influenzae type b, hepatitis b if such child was born after December 31, 1993, and varicella if such child was born after December 31, 1996, and against any other disease for which vaccination is recommended in the current schedule for active immunization adopted by the Commissioner in accordance with Connecticut General Statutes Section 19a-7f.

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(2) The provider shall admit no child to a family day care home unless such child's parent furnishes documentation of age-appropriate immunization, immunization-in-progress or exemption to immunization as specified in subdivision (3) of this subsection.

(3) For each enrolled child, the provider shall obtain from the child's parent and keep on file at the family day care home one or more of the following types of documentation for each of the diseases listed in subdivision (1) of this subsection:

(A) a statement signed and dated by a physician, physician assistant, or an advanced practice registered nurse indicating that the child is current or in progress with immunizations according to the schedule adopted by the Commissioner in accordance with Connecticut General Statutes Section 19a-7f and that names the appointment date for the child's next immunization;

(B) a statement signed and dated by a physician, physician assistant, or an advanced practice registered nurse indicating that the child has an appointment that will keep the immunizations current or in progress as required by said schedule and that names the date for the child's next immunization;

(C) a statement signed and dated by a physician, physician assistant, or an advanced practice registered nurse indicating that the child has laboratory confirmed proof of immunity to natural infection, or, in the case of varicella, a statement signed and dated by a physician, physician assistant, or an advanced practice registered nurse indicating that the child has already had chickenpox based on family and/or medical history;

(D) a statement signed and dated by a physician, physician assistant, or an advanced practice registered nurse indicating that the child has a medical contraindication to immunization;

(E) a written statement that immunization is contrary to the religious beliefs and practices of the child or the parent of such child. Such statement shall be signed by the child's parent.

(4) For each child to whom subparagraph (B) of subdivision (3) of this section applies, continued enrollment in day care for more than thirty days after the named immunization appointment shall be contingent on the provider receiving written documentation from a physician, physician assistant, or an advanced practice registered nurse stating either: that the named appointment was kept and the child received the scheduled immunizations, or that the child was unable to receive the scheduled immunizations for medical reasons and a new appointment date is named.

(Effective September 1, 1993; Amended August 8, 1995; Transferred January 29, 1996; Amended August 29, 1996; Amended December 28, 1999)

Sec. 19a-87b-11. Sick child care

(a) A family day care provider may choose to continue caring for a mildly ill child under the following circumstances:

(1) The child does not have a fever exceeding 101 degrees F, more than one undiagnosed episode of diarrhea or vomiting, or an undiagnosed skin rash.

(2) The child attends the facility on a regular basis. No child shall be accepted for sick

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child care on a drop in basis.

(3) Universal precautions and sanitary practices are used to prevent the spread of infection.

(Effective September 1, 1993; Transferred January 29, 1996)

Sec. 19a-87b-12. Night care

(a) The provider is responsible for meeting the following additional conditions if care extends into the child's normal sleeping hours:

(1) **A Separate Bed**

A separate bed, appropriate to the child's age, with individual, clean bedding, shall be provided.

(2) **Proper Location of the Bed**

The bed shall be located in a quiet part of the facility, and for a child six (6) years of age or older, shall not be in a room shared with another child of the opposite sex nor with any adult. For a child younger than three (3) years of age, the bed shall be on the same floor as the provider or a responsible adult.

(3) **Appropriate, Comfortable Sleepwear**

In preparation for sleep, the child shall be dressed in appropriate, comfortable sleep wear as agreed to by the parent of the child.

(Effective September 1, 1993; Transferred January 29, 1996)

Sec. 19a-87b-13. Department access, inspection and investigation during home visits

(a) **Access**

The provider or substitute shall allow Department staff access to the facility named on the registration, whenever Department staff seeks to perform home visits. The provider may request to see a picture identification card identifying the Department staff member. If a provider does not consent to departmental access for the performance of a home visit, Department staff will not enter the residence. However, failure of the provider to allow access to the facility for a home visit is deemed substantial noncompliance with this regulation and is an automatic ground for the Commissioner to initiate registration suspension or revocation proceedings.

(b) **Inspection of Facility**

The provider or substitute shall allow Department staff to inspect, upon request, any part of the family day care facility during the performance of a home visit. If a provider does not consent to departmental inspection of a part of the day care facility, Department staff will not inspect that part of the facility. However, failure of the provider to allow a complete inspection may be grounds for the initiation of registration suspension or revocation proceedings. A copy of the interview/home visit report form completed during the home visit shall be left with the provider.

(c) **Inspection of Records; Right to Contact Parents**

The provider or substitute shall allow Department staff to inspect, upon request, any

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records required to be maintained under Section 19a-87b-10 of these regulations, including enrollment records with information on the parents' names, addresses and telephone numbers. The Commissioner shall have the right at any time to contact and/or interview parents of any child who is receiving, or who has received, family day care services from the facility. With parental permission, the Commissioner may also talk to day care children who are receiving such services or who have received said services concerning the operation of the family day care home.

(d) Announced Home Visits

The Commissioner shall make announced home visits to inspect the facility at the time of initial application by a prospective provider or when there is a change of circumstances affecting the provider's registration such as a move to a new address where day care services are to be provided.

(e) Spot Inspections

The Commissioner shall make unannounced home visits, during customary business hours, to at least thirty-three and one-third (33.3%) percent of the registered family day care homes each year.

(f) Complaint Home Visits

The Commissioner shall make unannounced home visits to the family day care homes of registered or unregistered providers against whom complaints are lodged.

(Effective September 1, 1993; Transferred January 29, 1996)

Sec. 19a-87b-14. Complaint investigations

(a) Anonymity of Complainant

Any individual making a complaint against a day care applicant or provider may do so anonymously. If a complainant reveals his/her identity and requests confidentiality, the Department will not disclose the complainant's identity unless mandated by state or federal law.

(b) Confidentiality of Child Abuse and/or Neglect Investigations

For complaints that allege or that may constitute allegations of child abuse or neglect, detailed information, including but not limited to the identity of the complainant, shall be confidential. Information that can be disclosed would include the number, types and dates of the Department's contact with the provider about the complaint issues, the general status of a current investigation about the complaint or the Department's findings if the investigation has been completed.

(c) Duty to Investigate

The Department shall investigate each complaint that it receives concerning a registered or unregistered family day care home provider who is allegedly out of compliance with the requirements set forth in these regulations and any applicable provisions of the Connecticut General Statutes.

(d) Unannounced Home Visit; Notice and Interview

The investigation of a complaint may involve an unannounced home visit to the facility

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of the provider against whom the complaint was made. Department staff shall inform the provider that the home visit is being conducted pursuant to a complaint, and shall describe the nature of the complaint and alleged violations. The provider shall consent to an interview regarding the complaint, and shall discuss the subject matter of the complaint, so that the Department can assess its validity.

(e) Interviews

The investigation may include contacts and interviews with persons who have knowledge or information concerning the family day care home or provision of care including, but not limited to, the following:

- (1) parents and relatives of children receiving care;
- (2) children receiving care with parental permission;
- (3) social workers from the Department of Children and Families;
- (4) persons mentioned in the complaint;
- (5) fire inspectors, sanitarians or public health officials;
- (6) law enforcement personnel;
- (7) the registered provider and/or current or past substitutes and assistants; and
- (8) other individuals who may have information which may assist in the investigation of a complaint.

(f) Complaints Referred to Department of Children and Families

Complaints that allege and/or complaints that the Department determines may constitute child abuse or neglect shall be immediately reported to the Department of Children and Families.

(Effective September 1, 1993; Amended August 8, 1995; Transferred January 29, 1996)

Sec. 19a-87b-15. Agency action and appeal rights

(a) In accordance with the procedures set forth in sections 19a-79(b) and 19a-87e of the Connecticut General Statutes, if the department finds that the provider in the family day care home has failed to substantially comply with sections 19a-87b-1 through 19a-87b-18 of the Regulations of Connecticut State Agencies or conducts, operates or maintains a family day care home in a manner which endangers the health, safety and welfare of the children receiving family day care services, the department may, following a contested case hearing only, take any of the following actions singly or in combination against the license of the provider:

- (1) Revocation of the license;
- (2) Suspension of the license for a specific time period, or until regulatory compliance is secured, or conditions deemed necessary to protect the health, safety and welfare of the children cared for in the family day care home are met;
- (3) The imposition of a civil penalty of up to one hundred dollars (\$100.00) per day of violation of sections 19a-87b-1 to 19a-87b-18, inclusive, of the Regulations of Connecticut State Agencies; or
- (4) Place the license on probationary status and impose such conditions or corrective

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measures which the department deems necessary to assure the health, safety and welfare of the children cared for in the family day care home, including but not limited to:

(A) Reporting regularly to the department upon the matters which are the basis of probation;

(B) Placement of restrictions upon the operation of the family day care home deemed necessary to protect the health, safety and welfare of the children cared for in the family day care home; and

(C) Continue or renew professional education until a satisfactory degree of skill has been attained in those areas which are the basis for the probation.

(b) Denial of applications and renewals

A license may be denied or its renewal refused whenever the Commissioner is satisfied that the family day care provider fails to substantially comply with the regulations prescribed by the Commissioner or conducts, operates or maintains a family day care home in a manner which endangers the health, safety and welfare of the children receiving family day care services.

(c) Summary Suspension of a License

Summary suspension of a family day care home license, pending proceedings for revocation or other action, including the completion of a Department of Children and Families investigation, may be ordered pursuant to subsection (c) of section 4-182 of the Connecticut General Statutes, whenever the Commissioner finds that the health, safety, or welfare of day care children requires emergency action and incorporates a finding to that effect in his order.

(d) Request for a Hearing

The provider may, within thirty (30) days after receipt of notification of an intended licensure action by the commissioner, send a written request to the Commissioner asking for a hearing. The Department's hearing procedures are governed by applicable provisions of the Uniform Administrative Procedure Act and the Department's Rules of Practice. In the absence of a timely request for a hearing one or more licensure actions shall be imposed.

(e) Parental Notification

In all cases where a summary suspension order has been issued in conjunction with a notice of proposed agency action, the provider shall so notify the parents of all children who would be expected to use the day care facility during the period of suspension. Such notification shall also be required when so ordered by the Commissioner in any notice of proposed agency action, which does not contain a summary suspension order. The notification described in this section shall be given within 24 hours of receipt by the provider of the notice of proposed agency action. Nothing in this section shall prevent the Department from directly notifying parents of day care children.

(f) Operating a Family Day Care Home Without a License; Civil Penalty

Any person or officer of an association, organization or corporation who shall establish, conduct, maintain or operate a family day care home without a current and valid license or in violation of these regulations is subject to a civil penalty of not more than one hundred

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dollars (\$100) a day for each day that such facility is operated without a license or in violation of these regulations pursuant to sections 19a-79(b) and 19a-87c of the Connecticut General Statutes.

(g) Operating a Family Day Care Home Without a License; Court Action by Attorney General

When evidence indicates that the provider is operating a family day care home without a valid license or in violation of the adopted regulations, the Commissioner may request the Attorney General to bring an action in the Superior Court for the judicial district in which the facility is located, to enjoin the provider from maintaining the family day care home without a license or in violation of the regulations pursuant to Section 19a-87d of the Connecticut General Statutes.

(Effective September 1, 1993; Amended August 8, 1995; Transferred January 29, 1996; Amended March 29, 2001)

Sec. 19a-87b-16. Public access to information

(a) Routine Requests

Any person may request and receive the following information about a family day care home from the Department on a routine basis:

- (1) Registration status, which indicates whether the facility is unregistered, registered, applying for registration, or is no longer registered due to suspension, revocation or voluntary withdrawal;
- (2) registration number;
- (3) capacity of the facility;
- (4) expiration date of the registration;
- (5) listing of substantiated complaints against a provider during the past year, excluding complaints for child abuse and neglect;
- (6) the date of the last home visit made by the Commissioner;
- (7) the status of any existing corrective action plan required to bring the provider into compliance with regulations;
- (8) any variances that have been granted by the Commissioner.

(b) Freedom of Information Requests

Any person requiring more detailed case specific information about a family day care home may file a written request with the Department in accordance with the Freedom of Information Act. A per page charge will be assessed for any information released, according to Departmental policies. A record of all freedom of information requests shall be kept by the Department. Providers shall be notified of all freedom of information requests concerning their case file, specifically the name of the person requesting the information, the date of the request and the information released.

(Effective September 1, 1993; Transferred January 29, 1996)

Sec. 19a-87b-17. Administration of medications

Family day care home providers are not required by this section to administer medications to children. If the provider accepts responsibility for the administration of medications of any kind, the provider shall comply with all requirements of this section and shall have a written policy and procedures at the facility governing the administration of medications which shall include, but not be limited to, the types of medication that shall be administered, parental responsibilities, staff responsibilities, proper storage of medication and record keeping. Said policies and procedures shall be available for review by the Commissioner during site inspections or upon demand and shall reflect best practice.

(a) Administration of Nonprescription Topical Medications Only

(1) Description

For the purposes of this section nonprescription topical medications shall include:

- (A) Diaper changing ointments free of antibiotic, antifungal, or steroidal components;
- (B) Medicated powders; and
- (C) Teething medications.

(2) Nonprescription Topical Medications Administration/Parent Permission Records

The written permission of the parent shall be required prior to the administration of the nonprescription topical medication and a medication administration record shall be written in ink and kept on file at the facility for each child administered a nonprescription topical medication. The medication administration record and parent permission shall become part of the child's health record when the course of medication has ended. The parent shall be notified of any medication administration errors immediately in writing and the error shall be documented in the record. The following information shall be included on a form as part of the medication administration record:

- (A) The name, address, and date of birth of the child;
 - (B) The name of the medication;
 - (C) The schedule and site of administration of the medication;
 - (D) A statement indicating that the medication has been previously administered to the child without adverse effect;
 - (E) The signature in ink of the family day care home provider or substitute receiving the parent permission form and the medication;
 - (F) The name, address, telephone number, signature and relationship to the child of the parent(s) authorizing the administration of the medication;
 - (G) The date and time the medication is started and ended;
 - (H) Medication administration errors; and
 - (I) The name of the person who administered the nonprescription topical medication.
- (3) Nonprescription Topical Medication/Labeling and Storage:**
- (A) The medication shall be stored in the original container and shall contain the following information on the container or packaging indicating :
 - (i) the individual child's name;
 - (ii) the name of the medication; and

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(iii) directions for the medication's administration.

(B) The medication shall be stored away from food and inaccessible to children.

(C) Any unused portion of the medication shall be returned to the parent.

(b) **Administration of medications other than nonprescription topical medications.**

(1) Training Requirements

(A) Prior to the administration of any medication, the licensed provider and any substitute(s) who are responsible for administering the medications shall first be trained by a physician, physician assistant, advanced practice registered nurse or registered nurse in the methods of administration of medications and shall receive written approval from the trainer which indicates that the trainee has successfully completed a training program as required herein. A provider or substitute trained and approved to administer medication shall also be present whenever a child who has orders to receive medication is enrolled and present at the facility.

(B) The training in the administration of medications shall be documented and shall include, but not be limited to, the following:

(i) objectives;

(ii) a description of methods of administration including principles and techniques, application and installation of oral, topical, and inhalant medication, including the use of nebulization machines, with respect to age groups;

(iii) administering medication to an uncooperative child;

(iv) demonstration of techniques by the trainer and return demonstration by participants, assuring that the trainee can accurately understand and interpret orders and carry them out correctly;

(v) recognition of side effects and appropriate follow up action;

(vi) avoidance of medication errors and the action to take if an error occurs;

(vii) abbreviations commonly used;

(viii) documentation including parent permission, written orders from physicians, and the record of administration;

(ix) safe handling including receiving medication from a parent, safe disposal, and universal precautions; and

(x) proper storage including controlled substances, in accordance with Section 21a-262-10 of the Regulations of Connecticut State Agencies.

(C) **Injectable Medications**

In addition to the above training, before a family day care provider or substitute may administer injectable medications, he shall have successfully completed a training program on the administration of injectable medications by a premeasured, commercially prepared syringe. The trainer who shall be a physician, physician assistant, advanced practice registered nurse or registered nurse, shall assure that the provider or substitute understands the indications, side effects, handling and methods of administration for injectable medication. Thereafter, on a yearly basis, the provider or substitute shall have their skills and competency in the administration of injectable medication validated by a physician,

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physician assistant, advanced practice registered nurse or registered nurse. Injectable medications shall only be given in emergency situations, by a premeasured commercially prepared syringe, unless a petition for special medication authorization is granted by the department.

(2) Training Approval Documents/Training Outline

(A) Upon completion of the required training program, the physician, physician assistant, advanced practice registered nurse or registered nurse who conducted the training shall issue a written approval to each provider or substitute who has demonstrated successful completion of the required training. Approval for the administration of oral, topical, and inhalant medications shall remain valid for three (3) years. Approval for the administration of injectable medications shall be valid for one (1) year. A copy of the approval shall be on file at the facility where the provider or substitute is employed and shall be available to department staff upon request.

(B) The written approval shall include:

(i) the full name, signature, title, license number, address and telephone number of the physician, physician assistant, advanced practice registered nurse or registered nurse who gave the training;

(ii) the location and date(s) the training was given;

(iii) a statement that the required curriculum areas listed in Sec. 19a-87b-17(b) (1) (B) and Sec. 19a-87b-17(b) (1) (C) when applicable were successfully mastered, and indicating the route(s) of administration the trainee has been approved to administer;

(iv) the name, address and telephone number of the provider or substitute who completed the training successfully; and

(v) the expiration date of the approval.

(C) The trainer shall provide the trainee with an outline of the curriculum content which verifies that all mandated requirements have been included in the training program. A copy of said outline shall be on file at the facility where the trainee is employed for department review. The department may require at any time that the provider obtain the full curriculum from the trainer for review by the department.

(3) Order From An Authorized Prescriber/Parent's Permission

(A) Except for nonprescription topical medications described in Section 19a-87b-17(a) (1), no medication, prescription or nonprescription, shall be administered to a child without the written order of an authorized prescriber and the written permission of the child's parent which shall be on file at the facility. Such medications may include:

(i) oral medications;

(ii) topical medications;

(iii) inhalant medications; or

(iv) injectable medications, by a premeasured, commercially prepared syringe, to a child with a medically diagnosed condition who may require emergency treatment.

(B) The written order from an authorized prescriber shall be on one form which shall indicate that the medication is for a specific child and shall contain the following

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information:

- (i) the name, address, and date of birth of the child;
- (ii) the date the medication order was written;
- (iii) the medication or drug name, dose and method of administration;
- (iv) the time the medication is to be administered;
- (v) the date(s) the medication is to be started and ended;
- (vi) relevant side effects and the authorized prescriber's plan for management if they occur;
- (vii) notation if the medication is a controlled drug;
- (viii) a listing of any allergies, reactions to, or negative interactions with foods or drugs;
- (ix) specific instructions from the authorized prescriber who orders the medication regarding how the medication is to be given;
- (x) the name, address and telephone number of the authorized prescriber ordering the drug;
- (xi) the authorized prescriber's signature; and
- (xii) the name, address, telephone number, signature and relationship to the child of the parent(s) giving permission for the administration of the drug by the provider or substitute.

(C) If the authorized prescriber determines that the training of the provider or substitute is inadequate to safely administer medication to a particular child, or that the means of administration of medication is not permitted under these regulations, that authorized prescriber may order that such administration be performed by licensed medical personnel with the statutory authority to administer medications.

(D) The provider or substitute shall administer medication only in accordance with the written order of the authorized prescriber and shall not administer the first dose of any medication, except in an emergency. The parent shall be notified of any medication administration errors immediately in writing and the error shall be documented in the record.

(E) Investigational drugs shall not be administered.

(4) Required Records

(A) Except for nonprescription topical medications described in Section 19a-87b-17(a)(1), individual written medication administration records for each child shall be written in ink, reviewed prior to administering each dose of medication and kept on file at the facility. The medication administration record shall become part of the child's health record when the course of medication has ended.

(B) The individual written administration record for each child shall include:

- (i) the name, address, and date of birth of the child;
- (ii) the name of the medication or drug;
- (iii) the dosage ordered and method of administration;
- (iv) the pharmacy and prescription number if applicable;
- (v) the name of the authorized prescriber ordering the drug;
- (vi) the date, time, and dosage at each administration;
- (vii) the signature in ink of the family day care provider or substitute giving the

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medication;

- (viii) food and medication allergies;
- (ix) level of cooperation from the child in accepting the medication;
- (x) the date and time the medication is started and ended; and
- (xi) medication administration errors.

(5) Storage and Labeling

(A) Medication shall be stored in the original child-resistant safety container. The container or packaging shall have a label which includes the following information:

- (i) the child's name;
- (ii) the name of the medication;
- (iii) directions for the medication's administration; and
- (iv) the date of the prescription.

(B) Except for nonprescription topical medications described in Section 19a-87b-17(a) (1), medication shall be stored in a locked area or a locked container in a refrigerator in keeping with the label directions away from food and inaccessible to children. Keys to the locked area or container shall be accessible only to personnel authorized to administer medication. Controlled drugs shall be stored in accordance with Section 21a-262-10 of the Regulations of Connecticut State Agencies.

(C) All unused medication shall be returned to the parent or destroyed if it is not picked up within one (1) week following the termination of the order, by flushing into sewerage or a septic system in the presence of at least one witness. The facility shall keep a written record of the medications destroyed which shall be signed by both parties.

(6) Petition For Special Medication Authorization

(A) A provider may petition the department to administer medications to a child cared for at the family day care home by a modality which is not specifically permitted under these regulations by submitting a written application to the department including the following information:

(i) a written order from an authorized prescriber containing the information for the specific child set forth in subsection (b) (3) (B) and a statement that the administration by the requested modality is the only reasonable means of providing medication and that the administration must occur during hours of the child's attendance at the family day care home;

(ii) a written training plan including the full name, signature, title, license number, address and telephone number of the physician, advanced practice registered nurse, physician assistant or registered nurse who shall provide the training, a detailed outline of the curriculum areas to be covered in training, and a written statement by the authorized prescriber that the proposed training is adequate to assure that the medication shall be administered safely and appropriately to the particular child;

(iii) the name, address and telephone number of the person(s) who shall participate in the training;

(iv) written permission from the child's parent; and

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(v) such other information that the department deems necessary to evaluate the petition request.

(B) After reviewing the submitted information, if the department determines that the proposed administration of medication for the particular child can be provided in a manner to assure the health, welfare and safety of the child, it may grant the petition. The department may grant the petition with any conditions or corrective measures which the department deems necessary to assure the health, safety and welfare of the child. The department shall specify the curriculum that the training program shall cover and the expiration date of the authorization provided in granting the petition. If the department grants the petition, no medication may be administered until after the proposed training program has been successfully completed and a written certification from the physician, advanced practice registered nurse, physician assistant or registered nurse who provided the training is submitted to the department. The certification shall include:

(i) the full name, signature, title, license number, address and telephone number of the physician, advanced practice registered nurse, physician assistant or registered nurse who provided the training;

(ii) the location and date(s) the training was given;

(iii) a statement that the curriculum approved by the department was successfully mastered and stating the modality of administration of medication that the trainee has been approved to administer; and

(iv) the name, address and telephone number of the person(s) who successfully completed the training.

(C) Copies of all documentation required under this subsection shall be maintained at the family day care home. The requirements of subsection (b) (4) and (b) (5) shall apply to the administration of medication authorized by petition.

(c) Department Action

(1) Cease and Desist Orders

(A) If the department determines that the health, safety or welfare of a child in the family day care home imperatively requires emergency action to halt the administration of medications by a provider or substitute in a family day care home, the department may issue a cease and desist order requiring the immediate cessation of the administration of medications by a provider or substitute in the family day care home. The department shall provide an opportunity for a hearing regarding the order within 10 business days of the date the order is issued. Upon receipt of the order, the provider or substitute shall cease the administration of all medications and provide immediate notification to the parents of all children under his care that no medications may be administered at the family day care home until such time as the cease and desist order is terminated.

(2) Other Action

In accord with the procedures set forth in Connecticut General Statutes Section 19a-87e, if the department finds that the provider or substitute in the family day care home fails to substantially comply with the regulations in this section or fails to administer medications

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in compliance with policies or procedures adopted for the family day care home, or administers medications in a manner which endangers the health, welfare or safety of the children cared for in the family day care home, the department may take any of the following actions singly or in combination against the license of the provider:

- (A) Revocation of the license;
- (B) Suspension of the license for a specific time period or until regulatory compliance is secured or conditions deemed necessary to protect the health, safety and welfare of the children cared for in the family day care home are met;
- (C) The imposition of a civil penalty of up to one hundred dollars (\$100.00) per day of violation of these regulations; or
- (D) Place the licensee on probationary status and impose such conditions or corrective measures which the department deems necessary to assure the health, safety and welfare of the children cared for in the family day care home including but not limited to:
 - (i) reporting regularly to the department upon the matters which are the basis of probation;
 - (ii) placement of restrictions upon the operation of the family day care home deemed necessary to protect the health, safety and welfare of the children cared for in the family day care home; and
 - (iii) continue or renew professional education until a satisfactory degree of skill has been attained in those areas which are the basis for the probation.

(d) **Emergency Distribution of Potassium Iodide.** Notwithstanding any other provisions of the Regulations of Connecticut State Agencies, during a public health emergency declared by the Governor pursuant to section 2 of public act 03-236 and, if authorized by the Commissioner of Public Health via the emergency alert system or other communication system, a family day care home provider licensed in accordance with section 19a-87b of the Connecticut General Statutes, or a substitute or an assistant approved in accordance with section 19a-87b-8 of the Regulations of Connecticut State Agencies and located at a family day care home, within a 10-mile radius of the Millstone Power Station in Waterford, Connecticut, shall be permitted to distribute and administer potassium iodide tablets to adults present or to a child in attendance at the family day care home during such emergency, provided that:

- (1) Prior written consent has been obtained by the family day care home provider for such provision. Written consent forms shall be provided by the family day care home provider to the parent(s) or guardian(s) each child currently enrolled or employees currently employed by the family day care home provider promptly upon the effective date of this subdivision. Thereafter, written consent forms shall be provided by the family day care home provider to the parent(s) or guardian(s) of each minor child upon enrollment and to each new employee upon hire. Such documentation shall be kept at the facility;
- (2) Each person providing consent has been advised in writing by the family day care home provider that the ingestion of potassium iodide is voluntary;
- (3) Each person providing consent has been advised in writing by the family day care

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home provider about the contraindications and the potential side effects of taking potassium iodide, which include:

- (A) persons who are allergic to iodine should not take potassium iodide;
- (B) persons with chronic hives, lupus, or other conditions with hypocomplementemic vasculitis should not take potassium iodide;
- (C) persons with Graves disease or people taking certain heart medications should talk to their physician before there is an emergency to decide whether or not to take potassium iodide; and,
- (D) side effects including minor upset stomach or rash.

(4) Only family day care home providers who have read the regulations pertaining to the administration of potassium iodide and approved substitutes and approved assistants who have been instructed by the family day care home provider in the administration of potassium iodide may distribute and administer potassium iodide to adults or minors for whom written consent has been obtained. Such instruction shall include, but not be limited to the following:

- (A) the proper use and storage of potassium iodide;
- (B) the recommended dosages of potassium iodide to be administered to children and adults as prescribed by the Food and Drug Administration.
- (5) Potassium iodide tablets shall be stored in a locked storage area or container, inaccessible to children.

(Adopted effective November 3, 1997; Amended January 4, 2005)

Sec. 19a-87b-18. The monitoring of diabetes in family day care homes

(a) Policy and Procedures

(1) All family day care homes at which the provider or substitute, as defined in section 19a-87b-2 of the Regulations of Connecticut State Agencies, will be administering finger stick blood glucose tests shall have written policies and procedures governing the administration of finger stick blood glucose tests to children diagnosed with diabetes mellitus. The policies and procedures shall address at least the following areas:

- (A) parental responsibilities;
- (B) staff training and responsibilities;
- (C) proper storage, maintenance, and disposal of test materials and supplies;
- (D) record keeping;
- (E) reporting test results, incidents, and emergencies to the child's parent or guardian and the child's physician, physician assistant, or advanced practice registered nurse; and
- (F) a location where the tests occur that is respectful of the child's privacy and safety needs.

(2) Said policies and procedures shall be available for review by the Department during facility inspections or upon demand.

(b) Training

(1) Prior to the administration of finger stick blood glucose tests, the provider or

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substitute shall have completed the following training requirements:

(A) a course approved by the Department in first aid, as verified by a valid first aid certificate on file at the facility; and

(B) additional training given by a physician, physician assistant, advanced practice registered nurse, registered nurse, certified emergency medical technician, or the child's parent or guardian according to written guidelines provided by the child's physician, physician assistant, or advanced practice registered nurse. The additional training shall include but not be limited to:

(i) the proper use, storage and maintenance of the child's individual monitoring equipment;

(ii) reading and correctly interpreting test results; and

(iii) appropriate actions to take when test results fail to fall within specified ranges indicated in the written order from the child's physician, physician assistant, or advanced practice registered nurse.

(2) The training shall be updated at least every three years, when a child with diabetes mellitus who requires finger stick blood glucose testing is present at the facility.

(3) Documentation that the provider or substitute has been trained to administer finger stick blood glucose tests shall be in writing and kept at the facility for review by the Department. Such documentation shall indicate:

(A) the subjects covered in training;

(B) the signature and title of the instructor;

(C) the signature and title of the trainee; and (D) the date the training was given.

(c) Administration of Finger Stick Blood Glucose Test

(1) Except as provided in subdivision (3) of this subsection, only providers and substitutes trained in accordance with subsection (b) of this section may administer the finger stick blood glucose test in a family day care home.

(2) Whenever a child diagnosed with diabetes mellitus who has orders to receive finger stick blood glucose monitoring is enrolled and present at the facility, a provider or substitute designated and trained to administer finger stick blood glucose tests shall be present at the facility.

(3) Upon the written authorization of the child's physician, physician assistant, or advanced practice registered nurse, and the child's parent or guardian, a child may self administer the finger stick blood glucose test under the direct supervision of the designated provider or substitute who has met the training requirements in subsection (b) of this section.

(4) Only those providers and substitutes trained to administer injectable medications as described in section 19a-87b-17(b) of the Regulations of Connecticut State Agencies and authorized to do so in writing by the child's parent or guardian and physician, physician assistant, or advanced practice registered nurse may administer glucagon in a prefilled syringe in emergency situations only.

(d) Equipment

(1) The child's parent or guardian shall supply the provider with the necessary equipment

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and supplies to meet the child's individual needs. Such equipment and supplies shall include at least the following items:

- (A) the child's blood glucose meter and strips;
- (B) an appropriate retracting lancing device used in accordance with infection control procedures;
- (C) tissues or cotton balls; and
- (D) fast acting carbohydrates to be given to the child as indicated in the written order from the child's physician, physician assistant, or advanced practice registered nurse for hypoglycemia.

(2) Such equipment and supplies shall be labeled with the child's name and shall remain in a locked storage area when not in use.

(3) The provider shall obtain a signed agreement from the child's parent or guardian that the parent or guardian agrees to check and maintain the child's equipment in accordance with manufacturer's instructions, restock supplies, and removes material to be discarded from the facility on a daily basis. All materials to be discarded shall be kept locked until it is given to the child's parent or guardian for disposal.

(e) Record Keeping

The provider shall keep the following records at the facility as part of the child's medical record, and shall update them annually or when there is any change in the information:

(1) A current, written order signed and dated by the child's physician, physician assistant, or advanced practice registered nurse indicating:

- (A) the child's name;
- (B) the diagnosis of diabetes mellitus;
- (C) the type of blood glucose monitoring test required;
- (D) the test schedule;
- (E) the target ranges for test results;
- (F) specific actions to be taken and carbohydrates to be given when test results fall outside specified ranges;
- (G) diet requirements and restrictions;
- (H) any requirements for monitoring the child's recreational activities; and
- (I) conditions requiring immediate notification of the child's parent, guardian, emergency contact, the child's physician, physician assistant, or advanced practice registered nurse.

(2) An authorization form signed by the child's parent or guardian which includes the following information:

- (A) the child's name;
- (B) the parent's or guardian's name;
- (C) the parent's or guardian's address;
- (D) the parent's or guardian's telephone numbers at home and at work;
- (E) two adult, emergency contact people including names, addresses and telephone numbers;
- (F) the names of the provider and substitutes designated to administer finger stick blood

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glucose tests and provide care to the child during testing;

(G) additional comments relative to the care of the child, as needed;

(H) the signature of the parent or guardian;

(I) the date the authorization is signed; and

(J) the name, address and telephone number of the child's physician, physician assistant, or advanced practice registered nurse.

(3) The provider or substitute shall notify the child's parent or guardian daily in writing of the results of all blood glucose tests and any action taken based on the test results, and shall document the test results and any action taken in the child's medical record.

(Adopted effective June 30, 1998)

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Subject

Retired Licensure for Nurses

Inclusive Sections

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Retired Licensure for Nurses

Sec. 19a-88-1. Definitions

For the purposes of sections 19a-88-1 to 19a-88-4, inclusive, of the Regulations of Connecticut State Agencies:

(1) “Licensee” means a licensed practical nurse, registered nurse or advanced practice registered nurse holding a current license pursuant to Chapter 378 of the Connecticut General Statutes.

(2) “Department” means the Department of Public Health.

(3) “Retired from the profession” means a licensee who does not intend to practice nursing for monetary compensation for a period of at least three years, who may provide volunteer nursing services.

(4) “Retired license” means a license that is issued to a licensee who is retired from the profession.

(5) “Good Standing” means the license is not revoked, suspended, subject to probation or any other restriction or an unpaid civil penalty.

(Adopted effective December 28, 2000)

Sec. 19a-88-2. Qualifications

(a) A licensee shall be eligible for conversion of his/her license into a retired license if such licensee:

- (1) Is retired from the profession;
- (2) Holds a current license in good standing; and
- (3) Is due to renew such license.

(b) An advanced practice registered nurse who holds a retired license shall maintain certification by a national certifying body as prescribed in section 19a-88(c)(2) of the Connecticut General Statutes.

(Adopted effective December 28, 2000)

Sec. 19a-88-3. Restrictions upon the scope of practice

Individuals who hold a retired license shall not:

- (1) Supervise or delegate nursing care; or
- (2) Practice nursing for monetary compensation.

(Adopted effective December 28, 2000)

Sec. 19a-88-4. Requirements for returning a retired license to a full, active license to practice

An individual who holds a retired license who wishes to return to active employment shall:

(1) Submit an application for licensure, on forms provided by the department, as an advanced practice registered nurse, registered nurse or licensed practical nurse;

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- (2) Hold a current retired license in good standing; and
- (3) Be subject to the provisions of sections 19a-14-1 through 19a-14-5 of the Regulations of Connecticut State Agencies.

(Adopted effective December 28, 2000)

License Renewal for Retired Dentists

Sec. 19a-88-5. Definitions

For the purposes of sections 19a-88-5 to 19a-88-10, inclusive, of the Regulations of Connecticut State Agencies:

- (1) “Licensee” means a dentist who holds a full and unrestricted license to practice dentistry issued pursuant to Chapter 379 of the general statutes.
- (2) “Department” means the Department of Public Health.
- (3) “Retired from the profession of dentistry” means a licensee who does not practice dentistry for monetary compensation.
- (4) “Retired license” means a license issued by the Department to a licensee who is retired from the profession of dentistry.
- (5) “Volunteer services without compensation” means the direct provision of dental services without compensation or teaching in an accredited dental or dental hygiene education program without compensation, except such services shall not include (A) prescribing or administering controlled substances under schedules I or II, or (B) owning or operating a dental practice.
- (6) “Good standing” means the license is not revoked, suspended, subject to probation or an unresolved complaint.

(Adopted effective April 3, 2009)

Sec. 19a-88-6. Good standing

A licensee in good standing may apply to the department for a retired license during the licensee’s renewal period provided the licensee is retired from the profession of dentistry. The application shall be on forms prescribed by the department. The application shall include a statement from the licensee that such licensee is retired from the profession of dentistry.

(Adopted effective April 3, 2009)

Sec. 19a-88-7. Display of license

A licensee holding a retired license and providing volunteer services without compensation must post, or be able to produce on request of a patient, a current retired license.

(Adopted effective April 3, 2009)

Sec. 19a-88-8. Continuing education

A licensee holding a retired license and providing volunteer services without compensation shall be in compliance with section 20-126c of the general statutes with regard to continuing education.

(Adopted effective April 3, 2009)

Sec. 19a-88-9. Professional liability insurance

A licensee holding a retired license and providing volunteer services without compensation shall be in compliance with the provisions of section 20-126d of the general statutes with regard to professional liability insurance.

(Adopted effective April 3, 2009)

Sec. 19a-88-10. Return to active employment

A licensee who holds a retired license and wishes to return to practice dentistry for monetary compensation shall submit to the department an application for reinstatement on a form prescribed by the department, pay the required application fee and meet the following requirements:

(1) A licensee who holds a retired license who has provided volunteer services without compensation within the two years immediately preceding the date of application shall provide:

(A) Written verification of licensure from each state where the licensee holds or has ever held a license to practice dentistry;

(B) Evidence satisfactory to the department documenting the applicant's provision of volunteer services without compensation within the two years immediately preceding the date of application for reinstatement; and

(C) Evidence satisfactory to the department of completion of twelve hours of continuing education as required pursuant to Section 20-126c of the general statutes completed within the twelve months immediately preceding the date of application.

(2) A licensee who has not provided volunteer services without compensation within the two years immediately preceding the date of the application for reinstatement shall provide:

(A) Written verification of licensure from each state where the licensee holds or has ever held a license to practice dentistry;

(B) Evidence satisfactory to the department of completion of twenty-five hours of continuing education required pursuant to Section 20-126c of the general statutes within the twelve months immediately preceding the date of application; and

(C) Evidence of successful completion of the clinical skills examination administered by the Northeast Regional Board of Dental Examiners, Inc. or its successor organization.

(Adopted effective April 3, 2009)

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Subject

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Sec. 19a-92a-1. Conditions for tattooing of human beings (Repealed)

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Conditions for Advanced Practice Registered Nurses, Registered Nurses, Physician Assistants and Technicians Engaged in Tattooing

Sec. 19a-92a-1. Conditions for tatooing of human beings (Repealed)

Repealed June 11, 2014.

(Adopted effective April 20, 1995; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

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The Sale of Turtles

Sec. 19a-102a-1. Caution notice requirements

(a) Each person who offers for sale a turtle, as defined in section 19a-102a of the Connecticut General Statutes, shall comply with the following notice requirements:

(1) The caution notice shall be:

(A) within three feet of each turtle enclosure or display;

(B) in plain unobstructed view;

(C) a minimum of 8 ½ by 11 inches in size;

(D) firmly attached to a wall or other structure; and

(E) the bottom edge not less than three feet nor the top edge more than six feet from the floor.

(2) The caution notice shall contain the following three parts, each separated by a horizontal four point rule or a space of at least one half inch:

(A) part one has the word “Caution” in capital letters set in Times Roman Bold font of at least 60 points and centered on the line;

(B) part two has the following set in Times Roman font of at least 25 points: “Turtles may carry and transmit germs (including *Salmonella*) to people.” The words “turtles” and “*Salmonella*” shall be in bold; and

(C) part three has the following centered heading in underlined Times Roman Bold font of at least 25 points: “Preventive Measures.” The heading shall be followed by these bulleted sentences set in Times Roman font of at least 25 points: “Wash hands after touching turtles or other reptiles or tank objects. Keep turtles in their tank to avoid contamination of surfaces in the home. Do not allow turtles or materials from their tank to contact food preparation areas. Households with people at increased risk for infection (e.g., immunocompromised persons, children less than 5 years of age, pregnant women) should consult a physician before purchase.”

(b) Notwithstanding subsection (a) of this section, a caution notice approved by the national Centers for Disease Control and Prevention which contains the same messages as specified in subdivision (2) of subsection (a) of this section, even if the phrasing is different, may be substituted for the caution message specified in subsection (a) of this section.

(Adopted effective October 7, 1997)

Sec. 19a-102a-2. Acknowledgment of caution notice

At the time of sale of a turtle:

(a) the seller shall furnish the buyer with a copy of the caution notice and information obtained from a veterinarian regarding the proper care and feeding for the species of turtle being sold; and

(b) the buyer or, if the buyer is less than 16 years of age, parent or guardian, shall sign and date a statement indicating that he has read the notice. Signatures may be collected in

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logbook format, provided the statement appears at the top of each page.

(Adopted effective October 7, 1997)

Sec. 19a-102a-3. Written verification of the source of the turtle

Written verification that the turtle was bred at a licensed commercial fish farm or aquaculture facility and was not collected from the wild shall be retained and available for inspection by the Commissioner of Agriculture by the seller or wholesale supplier of the seller. If retained by the wholesale supplier, the seller shall receive and retain a statement from the wholesale supplier that such verification is available for inspection. Requested written verification shall be provided by the seller within 24 hours of a request being made by the Commissioner of Agriculture.

(Adopted effective October 7, 1997)

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Subject

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Lead Poisoning Prevention and Control

Sec. 19a-111-1. Definitions

As used in sections 19a-111-1 thru 19a-111-11 inclusive:

(1) “Abatement” means any set of measures designed to eliminate lead hazards in accordance with standards established pursuant to Sections 20-474 through 20-482 and subsections (e) and (f) of Section 19a-88 of the Connecticut General Statutes and regulations of Connecticut State Agencies sections 19a-111-1 through 19a-111-11 and 20-478-1 and 20-478-2 including, but not limited to, the encapsulation, replacement, removal, enclosure or covering of paint, plaster, soil or other material containing toxic levels of lead and all preparation, clean-up, disposal and reoccupancy clearance testing.

(2) “Abatement area” means a room or area isolated with containment in accordance with subdivision 19a-111-4(c)(2) of the regulations of Connecticut State Agencies where lead abatement is occurring.

(3) “Accessible surface” means any surface which is below five (5) feet in height or is exposed in such a way that a child can come in contact with the surface.

(4) “Apparent lead concentration” (ALC) means the average of at least three displayed lead concentration readings taken using a direct reading type x-ray fluorescence analyzer.

(5) “Approved training course” or “approved refresher training course” means a training course or a refresher training course, respectively, approved by the department pursuant to Section 20-477 of the Connecticut General Statutes.

(6) “Atomic absorption spectrophotometer” (AAS) means an instrument which measures the lead content in parts per million (ppm) using a lead source lamp, a flame capable of measuring the absorbed energy and converting it to concentration.

(7) “Biological monitoring” means the analysis of a person’s blood and/or urine, to determine the level of lead contamination in the body.

(8) “Certificate” means a document issued by the department indicating successful completion of an approved training course.

(9) “Certified historic property” means any building, structure, or site which has been determined historic by the Connecticut Historical Commission. Historic properties must be included in or eligible for inclusion in the national or state registers of historic places.

(10) “Certified industrial hygienist” means a person possessing a certificate from the American Board of Industrial Hygiene which indicates that they have specific academic credentials, five years professional experience in industrial hygiene, and have passed an examination given by the American Board of Industrial Hygiene.

(11) “Certified lead inspector risk assessor” means any lead consultant who completes an appropriate approved training course and obtains a certificate as a lead inspector risk assessor from the department. A certified lead inspector risk assessor conducts inspections and collects and interprets information to assess the level of risk from lead hazards.

(12) “Certified lead abatement supervisor” means any person who completes an appropriate approved training course and obtains a certificate as a lead abatement supervisor from the department. A lead abatement supervisor oversees lead abatement activities.

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(13) “Certified lead abatement worker” means any person who completes an appropriate approved training course and obtains a certificate as a lead abatement worker from the department. A lead abatement worker performs lead abatement activities.

(14) “Certified lead inspector” means any lead consultant who completes an appropriate approved training course and obtains a certificate as a lead inspector from the department. A certified lead inspector conducts inspections to determine the presence of lead in paint, other surface coverings and various environmental media. The terms “lead inspector” and “inspector” mean “certified lead inspector” or “code enforcement official” as defined in subsection (20) of this section unless specifically noted otherwise.

(15) “Certified lead planner-project designer” means any lead consultant who completes an appropriate approved training course and obtains a certificate as a lead planner-project designer from the department. A certified lead planner-project designer designs lead abatement and management activities.

(16) “Chewable surface” means any projection one half (0.50) inch or greater from an interior or exterior surface up to five (5) feet in height that can be mouthed by a child. The chewable surface includes window sills, door frames, stair rails and stairs, two (2) inches back from any edge, and any other exterior and interior surface that may be readily chewed by children. Baseboards with an exposed horizontal edge may have quarter round molding applied to the top so that only vertical edges forming outside corners, if present, constitute a chewable surface.

(17) “Child” means a person under the age of six (6).

(18) “Child day care services” means a program of supplementary care in accordance with section 19a-77(a) of the Connecticut General Statutes.

(19) “Child day care center” means a program of supplementary care in accordance with section 19a-77(a)(1) of Connecticut General Statutes.

(20) “Code enforcement agency” means the local health department responsible for enforcing the public health code or the local housing agency responsible for enforcing housing code regulations or any other agency designated by the appropriate authority to enforce either the public health code or housing code regulations.

(21) “Code enforcement official” means the director of health or a person authorized by him to act on his behalf, the local housing code official or a person authorized by him to act on his behalf, or an agent of the commissioner.

(22) “Commissioner” means the commissioner of public health.

(23) “Common area” means a room or area that is accessible to all tenants in a building (e.g. hallway, boiler room).

(24) “Containment” means a process for protecting workers, residents, and the environment by controlling exposures to lead dust and debris created during abatement.

(25) “Confirmatory testing” means analysis using atomic absorption spectrophotometry (AAS), graphite furnace atomic absorption spectrophotometry (GFAAS), inductively coupled plasma atomic emission spectrophotometry (ICP-AES), or x-ray fluorescence spectrum analysis spectrometry with a 240 second spectrum analyzer test.

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(26) “Corrected lead concentration” (CLC) means the difference between the average displayed lead concentration readings (using a direct reading type x-ray fluorescence analyzer) taken on a painted surface and the average of three readings taken on a bare substrate (substrate contribution).

(27) “Department” means the department of public health.

(28) “Defective surface” means peeling, flaking, chalking, scaling or chipping paint; paint over crumbling, cracking or falling plaster, or plaster with holes in it; paint over a defective or deteriorating substrate; or paint that is damaged in any manner such that a child can get paint from the damaged area.

(29) “Director” means the director of the state program for childhood lead poisoning prevention.

(30) “Dwelling” means every building or shelter used or intended for human habitation, including exterior surfaces and all common areas thereof, and the exterior of any other structure located within the same lot, even if not used for human habitation.

(31) “Dwelling unit” means a room or group of rooms within a dwelling arranged for use as a single household by one or more individuals living together who share living and sleeping facilities.

(32) “Elevated blood lead level” means a blood lead concentration equal to or greater than twenty (20) micrograms per deciliter (ug/dl) or as defined by Connecticut General Statutes section 19a-111.

(33) “Encapsulation” means resurfacing or covering surfaces, and sealing or caulking with durable materials, so as to prevent or control chalking, flaking substances containing toxic levels of lead from becoming part of house dust or accessible to children.

(34) “Entity” means any person, partnership, firm, association, corporation, sole proprietorship or any other business concern, state or local government agency or political subdivision or authority thereof, or any religious, social or union organization, whether operated for profit or otherwise.

(35) “Epidemiological investigation” means an examination and evaluation to determine the cause of elevated blood lead levels. An epidemiological investigation will include an inspection conducted by a lead inspector to detect lead-based paint and report of findings. This investigation must also include evaluation of other sources such as soil, dust, pottery, gasoline, toys, or occupational exposures, to determine the cause of elevated blood lead levels. The investigation may also include isotopic analysis of lead-containing items.

(36) “Family day care home” means a program of supplementary care in accordance with section 19a-77(a)(3) of Connecticut General Statutes.

(37) “Graphite furnace atomic absorption spectrophotometer” (GFAAS) means an instrument that functions the same as an AAS, with one exception, i.e., the flame is replaced by an electrically heated chamber, a graphite tube, into which the sample is deposited.

(38) “Group day care home” means a program of supplementary care in accordance with section 19a-77(a)(2) of Connecticut General Statutes.

(39) “High efficiency particulate air” (HEPA) means a type of filtering system capable

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of filtering out particles of 0.3 microns or greater diameter from a body of air at 99.97% efficiency or greater.

(40) “High phosphate detergent” is detergent which contains at least five (5%) percent tri-sodium phosphate (TSP).

(41) “Inductively coupled plasma-atomic emission spectrophotometer” (ICP-AES) is an instrument which measures lead in ppm using a heat source (plasma torch) to dissociate and ionize lead atoms thereby emitting energy. This emission energy is measured and converted to concentration by the detector.

(42) “Intact surface” means a defect-free surface with no loose, peeling, chipping or flaking paint. Painted surfaces must be free from crumbling, cracking or falling plaster and must not have holes in them. Intact surfaces must not be damaged in any way such that a child can get paint from the damaged area.

(43) “Isotopic analysis” means a physicochemical method which differentiates between chemical elements having different atomic weight and electrical charge.

(44) “Lead-based” refers to paints, glazes, and other surface coverings, containing a toxic level of lead.

(45) “Lead abatement plan” means a written plan that identifies the location of intact and defective lead-based paint and describes how defective lead-based surfaces will be abated and how the environment, health, and safety will be protected. The plan also identifies the location of soil containing lead and describes sampling protocol used and abatement options.

(46) “Lead consultant” means any person who performs lead detection, risk assessment, abatement design or related services in disciplines including, but not necessarily limited to, inspector, inspector risk assessor and planner-project designer.

(47) “Lead management plan” means a written plan that describes how an intact surface with lead-based paint will be monitored to ensure that defective paint surfaces will be identified and abated.

(48) “Licensed lead abatement contractor” means any entity that contracts to perform lead hazard reduction by means of abatement including, but not limited to, the encapsulation, replacement, removal, enclosure or covering of paint, plaster, soil or other material containing toxic levels of lead and obtains a license from the department to conduct such abatement work. The contractor utilizes certified lead abatement supervisors to oversee such lead abatement activities and certified lead abatement workers to perform such abatement activities. The terms “lead abatement contractor” and “abatement contractor” mean “licensed lead abatement contractor” unless specifically noted otherwise.

(49) “Licensed lead consultant contractor” means any entity that contracts to perform lead hazard reduction consultation work utilizing an inspector, inspector risk assessor and/or planner-project designer and obtains a license from the department to conduct such consultation work. The terms “lead consultant contractor” and “consultant contractor” mean “licensed lead consultant contractor” unless specifically noted otherwise.

(50) “Owner” means any person, partnership, firm, association, corporation, sole

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proprietorship or any other business concern, state or local government agency or political subdivision or authority thereof, or any religious, social or union organization, whether operated for profit or otherwise, who, alone or jointly with others owns, holds, or controls the whole or any part of the deed or title to any property. No holder of an easement, mortgagee, bank or lender holding the mortgage, shall be considered an owner except when the holder of an easement, mortgagee, banker, or lender takes physical possession of the property.

(51) “Paint removal” means a strategy of abatement which entails stripping lead paint from surfaces.

(52) “Replacement” means a strategy of abatement which entails the removal of components such as windows, doors and trim that contain toxic levels of lead and installing new components which are lead free.

(53) “Secretary of Interior’s Standards for Rehabilitation and Guidelines for Rehabilitating Historic Buildings” means the guidelines and methods approved by the state and federal governments for alterations to historic properties (36 CFR section 67).

(54) “State laboratory for lead and lead poisoning detection” means the laboratory established by the commissioner, for the purpose of analyzing blood specimens from persons for the presence of lead; and analyzing samples of paint, plaster, soil and other materials, within the laboratory or on site with mobile units, for toxic levels of lead.

(55) “State program” means the childhood lead poisoning prevention program established by the department.

(56) “Substrate” means the underlying surface which remains after paint is removed.

(57) “Substrate equivalent lead” (SEL) means the average of at least three displayed lead concentration readings with a direct reading type x-ray fluorescence analyzer after paint is removed from the substrate.

(58) “Target housing” means any housing constructed prior to 1978, except any zero-bedroom dwelling unit or any housing for the elderly or persons with disabilities unless a child resides or is expected to reside in such dwelling unit or housing.

(59) “Toxic level of lead” means a level of lead that:

(A) when present in paint offered for sale for use on or in a residential dwelling contains greater than 0.06 percent lead by weight as measured by atomic absorption spectrophotometry (AAS), graphite furnace atomic absorption spectrophotometry (GFAAS), inductively coupled plasma-atomic emission spectrophotometry (ICP-AES) or another accurate and precise testing method that has been approved by the commissioner, by a laboratory approved by the department for lead analysis.

(B) when present in a dried paint, plaster or other accessible surface on or in a residential dwelling contains equal to or greater than 0.50 percent lead by dry weight as measured by atomic absorption spectrophotometry (AAS), graphite furnace atomic absorption spectrophotometry (GFAAS), inductively coupled plasma-atomic emission spectrophotometry (ICP-AES) or another accurate and precise testing method that has been approved by the commissioner, by a laboratory approved by the department for lead

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analysis, or equal to or greater than 1.0 milligrams lead per square centimeter of surface as measured on site by an X-ray fluorescence analyzer or another accurate and precise testing method that has been approved by the commissioner.

(60) “Treatment” means any method, technique or process designed to change the physical chemical, or biological character or composition of any hazardous waste so as to render it non-hazardous, or to recover it, or to make it safer to transport, store or dispose of, or to make it amenable for recovery, storage, or volume reduction.

(61) “TSP” means tri-sodium phosphate. A TSP solution contains at least 5% TSP or its equivalent.

(62) “X-ray fluorescence analyzer (XRF)” means an analytical instrument that measures lead concentration of dried paint on surfaces or in a laboratory sample in milligrams per square centimeter (mg/cm²) using a radioactive source within the instrument.

(Effective September 29, 1992; Amended November 29, 1995; Amended July 25, 1997; Amended September 30, 2003)

Sec. 19a-111-2. Applicability of regulations

(a) When a child resides in a dwelling unit all defective lead-based surfaces shall be abated. A property owner may not avoid abatement by taking eviction action against a family with a child.

(b) When a child resides in a dwelling all defective exterior surfaces and all defective surfaces in common areas containing toxic levels of lead shall be abated.

(c) When a child has an elevated blood lead level then abatement shall include all lead-based chewable surfaces whether or not that surface is defective and all lead-based movable parts of windows and surfaces that rub against movable parts of windows.

(d) When a child resides in a dwelling requiring lead abatement, interior dust, drinking water and exterior soil shall be assessed. When soil or sand areas that are not covered by grass, sod, other live ground covers, wood chips, gravel, artificial turf, or similar covering are found to contain lead concentrations in excess of 400 parts per million, such bare soil or sand areas shall be abated. When lead dust hazards are found to be a source or a potential source of elevated blood lead in a child, lead dust shall be reduced to a safe level using appropriate cleaning methods. When lead in drinking water is determined to be a source or potential source of elevated blood lead in a child, appropriate remedial action approved by the local director of health shall be implemented.

(e) Intact surfaces containing toxic levels of lead except as noted in section 19a-111-2 (c) of regulations of Connecticut State Agencies are not required to be abated by these regulations, however, when a child resides in a dwelling the owner shall have a lead management plan written within sixty (60) days of receipt of inspection results. The plan shall be implemented and kept by the owner and transferred with ownership upon transfer of title. The management plan shall identify the location of intact lead surfaces and describe how these intact surfaces will be monitored on a regular basis by the owner to ensure that if they become defective, the surfaces will be identified and abated. The plan must be

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submitted to the local director of health or the commissioner upon request.

(f) Repealed, November 29, 1995.

(Effective September 29, 1992; Amended November 29, 1995; Amended September 30, 2003)

Sec. 19a-111-3. Inspections, reports and notifications

(a) **Methods**—Lead inspectors may conduct inspections, tests and measurements and issue reports on forms prescribed by the Department for the purpose of recording the presence of toxic levels of lead. When used to determine compliance with Connecticut General Statutes section 19a-111 and regulations of Connecticut State Agencies Sections 19a-111-1 through 19a-111-11, such reports shall be based upon X-ray fluorescence (XRF), atomic absorption spectrophotometry (AAS) graphite furnace atomic absorption spectrophotometry (GFAAS), or inductively coupled plasma-atomic emission spectrophotometry (ICP-AES). Paint samples taken for AAS, GFAAS, or ICP-AES analysis shall be a minimum size of 1 square inch and shall contain all layers of paint down to the substrate.

(1) Surface testing sites—

(A) Interior Locations—In each area of an interior location (e.g. back room, closet, pantry, hall, or part of a divided room), the following representative surfaces will be tested for the presence of toxic levels of lead: baseboard, ceiling, crown molding, door surface and side of door frame for a representative interior door, floor, fireplace, radiator, shelf, shelf support, stair riser, stair tread, stair stringer, stair newel post, stair railing cap, stair balustrade, upper wall, lower wall, chair rail, window sash and window casing and window sill for a representative window, representative door and window lintel.

(B) Exterior Locations—For each side of an exterior surface the following representative surface will be tested for the presence of toxic levels of lead: bulkhead, porch, entrance canopy, exterior wall, siding, lattice, ceiling, railing, railing cap, stair stringer, stair tread, stair riser, trim, cellar window unit, window sill, window casing, window sash for a representative window.

(2) Testing protocols for determining lead present at or above the toxic level using XRF analyzer instruments

(A) The methodology shall be consistent with performance characteristics specific to each make and model of instrument so as to maintain accuracy and precision. Readings shall be classified as (1) lead present at or above the toxic level of lead as defined in section 19a-111-1(59), (2) inconclusive or (3) lead not present at or above the toxic level. Instruments used to determine these classifications shall have verified accuracy and precision utilizing x-ray fluorescence performance characteristic sheets published jointly by the United States Environmental Protection Agency and the United States Department of Housing and Urban Development. The performance characteristic sheets describe the methodology to be used for obtaining x-ray fluorescence readings taken on specific substrates, calibration check tolerances, and provide information describing the performance of the specific model of x-ray fluorescence instrument, including inconclusive ranges.

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(B) Multifamily dwelling protocols and decision flowcharts shall not be acceptable methodology for residential lead inspections conducted pursuant to section 19a-111-3 (a) (1).

(C) XRF testing of representative surfaces as described within section 19a-111-3 (a) (1) shall require testing of a representative surface on each listed component when present within an interior area (e.g. room, closet, pantry, hall) or on an exterior side of a building. When multiple readings are required upon a component per performance characteristic sheet protocol, these readings shall be taken on different locations upon the component testing surface. The average of the multiple readings shall then be used to determine the classification of the readings as described within subdivision (2) (A) of this subsection and within the performance characteristic sheet for the specific model of the XRF instrument used to obtain the readings. An inspector or inspector risk assessor may terminate the series of readings when an individual reading or readings are sufficiently high so as to substantiate a conclusion that lead is present at or above the toxic level without completion of the full test sequence.

(D) When the reading classification obtained from a surface has been determined to be within the inconclusive range, confirmation shall be required except as noted in this subsection. Confirmation shall be performed through testing with atomic absorption spectrophotometry (AAS), graphite furnace atomic absorption spectrophotometry (GFAAS), inductively coupled plasma atomic emission spectrophotometry (ICP-AES), or another testing protocol deemed acceptable by the commissioner. Alternatively at the discretion of the owner and in lieu of confirmation, (1) a surface that is found to be within the inconclusive range may be presumed to contain a toxic level of lead and abated with no further confirmation or (2) an intact surface, except for those noted in subsection (c) of section 19a-111-2, may be placed under the auspices of a lead management plan without confirmatory testing. If deterioration occurs on any such intact surface, the owner shall provide confirmatory testing of that surface and abate the surface if found to contain a toxic level of lead or, at the discretion of the owner, abate any such defective surface as containing a toxic level of lead, without further confirmatory testing.

(E) XRF testing shall be immediately preceded by a minimum of three calibration check readings. Calibration check readings shall be made immediately after an inspection has been completed. Additional calibration check readings shall be made every 4 hours during an inspection or as indicated by the manufacturer, whichever is more frequent. Calibration check readings shall be within the calibration check tolerances outlined in the performance characteristic sheet of the model being utilized before the inspection may proceed. Calibration check readings shall be logged within the inspection documents by the inspector.

(F) XRF instruments may be used to test surfaces that are flat and accessible to the measuring probe of the instrument. XRF instruments shall not be used to test surfaces that are curved, ornate or inaccessible.

(G) For those XRF instruments that require substrate correction, apparent lead concentration (ALC) analysis results may be used to determine that lead is present at or

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above the toxic level when an ALC result is greater than or equal to 4.0 mg/cm².

(H) Where manufacturer's protocol including calibration check criteria are more stringent than those specified in the performance characteristic sheet for that XRF, the manufacturer's protocol shall take precedence.

(b) **Soil**—The methodology for sampling soil for lead varies depending on the site. The methodology used shall be detailed in the lead abatement plan.

(c) **Inspection priorities**—Code enforcement agencies shall carry out inspections according to the following priorities:

(1) **Elevated blood lead level**—As part of an epidemiological investigation of a child's elevated blood lead level, dwelling units in which the child resides shall be inspected for toxic levels of lead by the local director of health. This epidemiological investigation shall begin within five (5) working days after notification of the local director of health by the child's physician, hospital, clinic or by the state lead poisoning prevention program and be completed as expeditiously as possible.

(2) **Other dwellings**—Inspections shall begin within thirty (30) working days and be completed as expeditiously as possible in all dwelling units in which a child resides in the same building as those identified under section 19a-111-3 (c) (1) of regulations of Connecticut State Agencies.

(3) **Child day care services**—Before licensure or relicensure of a child day care center or group day care home by the department, or before registration of a family day care home by the State of Connecticut department of human services, the premises in which the services are provided shall be inspected by a lead inspector for toxic levels of lead.

(d) **Report of inspection**—Whenever an inspector finds a toxic level of lead requiring abatement, the inspector shall report this to the owner, local director of health, and the commissioner. This report shall include a properly completed copy of the inspection form prescribed by the department and shall be postmarked and sent by certified mail or hand delivered by the end of the second working day following completion of the inspection. The inspection form will indicate all defective and intact lead-based surfaces. Soil and dust exposure pathways shall be investigated and the potential for lead poisoning to a child assessed. Soil sampling methodology shall be documented.

(e) **Notification**—Within two (2) days after receipt of an inspection report identifying toxic levels of lead requiring abatement the owner shall have posted notice on each entrance to the dwelling unit or common area of dwelling if affected. The notice shall measure at least 8 ½" x 11" with letters measuring at least one half (½) inch. The notice shall state that the dwelling unit contains a toxic level of lead which may be dangerous and which a child should not be allowed to mouth or chew. The notice shall not be removed until the dwelling unit has been found to comply with Connecticut General Statutes section 19a-111 and regulations of Connecticut State Agencies sections 19a-111-1 through 19a-111-11. The owner will provide a summary report of the lead inspection and/or lead management plan, and the post-abatement inspection report to the residents. This summary inspection report will contain the results of lead-based surface testing as required by section 19a-111-3 of the

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regulations of Connecticut State Agencies and will include a description of the testing methods used. The owner shall also provide the residents with information prescribed by the department concerning the toxicity of lead and precautions that should be taken to avoid exposure.

(f) **Corrective action**—The local code enforcement agency shall issue an order to correct all defective lead-based surfaces requiring abatement and soil areas identified as a source, or potential source for elevated blood lead within the time period specified in section 19a-111-5 of regulations of Connecticut State Agencies.

(g) **Identification and certification of historic properties**—When a dwelling is fifty (50) years old or older and requires lead abatement, the owner shall within five (5) working days after completion of the inspection report postmark or hand deliver an inspection report and a good quality photograph of the property to the Connecticut Historical Commission. The commission will determine whether properties over fifty (50) years old which require lead abatement are historic in order to provide guidance on which lead abatement techniques are appropriate for historic properties. The commission will certify properties which are included in or eligible for inclusion in the national or state registers of historic places. The commission shall within ten (10) working days after receipt of the inspection report and photograph send by first class mail a written report of the building's historic status.

(h) **Post abatement inspection**—consists of:

(1) **Reinspection**: All areas where abatement has been completed in accordance with the abatement plan mandated in section 19a-111-4 (a) of the regulations of Connecticut State Agencies shall be reinspected by the code enforcement agency within ten (10) working days after notification has been received from the owner that lead abatement has been completed. The inspection shall ascertain whether the defective lead based paint has been properly abated. A lead abatement project shall be considered complete when all defective lead based paint has been abated, there is no visible residue in the work area, and the level of lead has been reduced in the abatement area to below the toxic level of lead as determined by the use of lead in dust sampling in the abatement area. A copy of the post abatement inspection report shall be sent by certified mail or hand delivered to the owner of the residential property, the local director of health and the commissioner within two (2) working days after the reinspection is completed.

(2) **Lead in dust sampling: Wipe sampling procedure**—The standard sample size in this technique is one square foot, which is obtained with a plastic template or measuring device according to the following formula: length in inches times width in inches divided by 144 equals the fraction or multiple of one square foot. Disposable gloves are worn throughout the sampling procedure. A pre-moistened wipe or towelette is placed flat on the surface to be sampled. The wipe is rubbed in an “S” pattern over the entire measured area. The wipe is then folded in half and rubbed once over the surface again at a 90 degree angle to the first series of wipes. Finally, the wipe is folded and placed in a marked tube or plastic bag for laboratory determination of lead via AAS, GFAAS, or ICP-AES. A minimum of 2 unused wipes or 1 wipe for every 20 used, whichever number is greater, is submitted to the

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laboratory as a blank.

(i) **Conflict of interest**—The lead inspector shall not be an owner or the lead abatement contractor for any property for which the lead inspector issues a lead inspection report.

(j) **Risk Assessment**—For the purpose of assessing the level of risk from lead dust, a lead dust hazard is present when the concentration of lead in dust is equal to or exceeds the following.

(A) floors – 40 mg/sq. ft. (micrograms per square foot);

(B) window sills – 250 mg/sq. ft.

(Effective September 29, 1992; Amended July 25, 1997; Amended September 30, 2003)

Sec. 19a-111-4. Abatement of toxic levels of lead

(a) **Lead abatement plan**—When toxic levels of lead requiring abatement have been identified the owner shall have a written lead abatement plan prepared and submitted to the local director of health according to the time period for compliance listed in section 19a-111-5 of regulations of Connecticut State Agencies. The local director of health shall review the plan for completeness and compliance with sections 19a-111-1 through 19a-111-11 of the regulations of Connecticut State Agencies. The plan shall describe repair work necessary prior to abatement, all surfaces and soil areas containing toxic levels of lead, the sampling and testing methodologies utilized, how surfaces and soil areas requiring abatement will be abated, clean up procedures, and clearance testing prior to reoccupancy. The plan shall state estimated starting and completion dates for the abatement project. The abatement project shall follow the plan and be in compliance with section 19a-111-1 through 19a-111-11 of the regulations of Connecticut State Agencies. If the property is a certified historic property as identified according to section 19a-111-3 (g) of the regulations of Connecticut State Agencies the lead abatement plan must also be submitted to the Connecticut Historical Commission for review. Review of the plan by the Connecticut Historical Commission will be completed and state if the lead abatement plan proposes to use lead abatement techniques which are appropriate for historic properties. This written review shall be postmarked within ten (10) working days of receipt of the abatement plan and be sent to the owner and local director of health. If the plan requires revision the local director of health shall establish a time table for development of a revised plan with the owner.

(b) **Notice to residents**—Prior to beginning a lead abatement project, the owner shall give the affected premises or dwelling unit residents a minimum of five (5) working days written notice of the date the abatement will begin. This notice shall inform the residents of their rights and responsibilities in accordance with general statutes section 19a-111 and sections 19a-111-1 through 19a-111-11 of the regulations of Connecticut State Agencies and state which surfaces or soil areas shall be abated.

(c) **Methods of abatement**—The owner of a dwelling is responsible for proper abatement of toxic levels of lead in dwelling units where a child resides. All defective paint, plaster or other material containing toxic levels of lead on both interior and exterior surfaces and soil areas and fixtures shall be adequately abated by proper preparation, containment,

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abatement, clean-up, and waste disposal.

(1) Preparation prior to abatement

(A) Post warnings—Warning signs shall be placed at all entrances and exits to abatement area.

(B) Packing residents' belongings—The residents shall pack their belongings in easily handled containers. The owner shall have these belongings moved from the abatement area to a secure area where the residents can have access to their belongings on a daily basis. Belongings must be moved unless abatement methods of replacement or encapsulation are used in a limited area and very little dust is expected to be generated and the abatement plan specifies that the belongings will remain in the abatement area.

(C) Covering residents' belongings—The abatement contractor shall ensure that all permanent fixtures are covered with 6 mil polyethylene sheeting and sealed with duct tape.

(D) Repair work prior to abatement—Prior to abatement, repairs shall be made to pre-existing conditions that may impede abatement including water leaks and inadequate heat. A description of these repairs shall be summarized in the lead abatement plan.

(2) Containment—The abatement area shall be properly contained using materials such as 6 mil polyethylene sheeting to prevent lead dust from contaminating the dwelling or environment.

(A) Cover objects—Nonmovable objects shall be covered with 6-mil polyethylene sheeting and floors shall be covered with two layers of 6-mil polyethylene sheeting.

(B) Air systems—Air heating and conditioning systems shall be turned off and air intake and exhaust systems shall be sealed.

(C) Entrances—Entrances to the abatement area shall be sealed by using two layers of 6-mil polyethylene sheeting (each layer attached to the top of the entrance and opposite side using heavy duty tape).

(D) Exterior—Exterior abatement shall have proper containment using 6-mil polyethylene sheeting to prevent release of lead into the environment.

(i) For liquid waste extend the end of the polyethylene sheets a sufficient distance to contain the runoff and raise the outside edge of the sheets to trap liquid waste.

(ii) For dry waste extend the sheeting out from the foundation a distance of three (3) feet per story being abated with a minimum of five (5) feet and a maximum of twenty (20) feet. Erect vertical shrouds to contain any potential dust release into the adjacent environment.

(3) Abatement—Defective lead-based surfaces requiring abatement shall be abated by either replacement, encapsulation or removal methods. Repainting or use of paper or vinyl wall covering without abating the defective lead-based surface does not constitute compliance with sections 19a-111-1 through 19a-111-11 of the regulations of Connecticut State Agencies. Appropriate worker protection practices shall be followed as specified in section 19a-111-6 of the regulations of Connecticut State Agencies.

(A) Replacement of surfaces containing toxic levels of lead—Old surfaces shall be removed and new surfaces that have no lead-based surfaces shall be installed.

(B) Encapsulation—A permanent cover shall be installed over the lead-based surface.

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Encapsulant materials shall bind to the substrate and not just the surface paint.

(C) Removal—Removal methods include:

- (i) heat based removal using heat guns with temperature not in excess of 700°F to prevent vaporization of lead (open flames shall not be used);
- (ii) chemical removal with caustic or solvent-based chemicals done either on site or components taken off site for removal of the lead-based surface;
- (iii) wet scraping by misting the surface and then scraping;
- (iv) sanding only with a HEPA vacuum attachment to collect dust;
- (v) for exterior lead-based surfaces only, this surface may be removed by abrasive blasting with a HEPA vacuum arrangement or contained water blasting or the methods listed above such that no visible emissions or residue can be observed. Uncontained abrasive blasting is not allowed. Soil shall be sampled for lead content according to methodologies specified in the lead abatement plan both before and after exterior lead abatement to ensure that containment, abatement, and clean-up are effective.

(4) Clean-up—Preliminary clean-up shall be done by wet sweeping the containment area and carefully removing the polyethylene covering by folding the plastic upon itself to trap all dust. After the polyethylene covering is removed the abatement area shall be HEPA vacuumed and then washed with TSP detergent. Then for final clean-up the abatement area shall be HEPA vacuumed, washed with TSP detergent, and HEPA vacuumed again. To give airborne lead time to settle, the final cleanup should be scheduled to start no sooner than twenty-four (24) hours after active abatement has ceased. Final clearance testing should be performed using lead in dust testing and XRF, GFAAS, AAS or ICP-AES after the final clean-up has been performed but before the removal of the polyethylene sheeting material that isolates the abatement area from the rest of the dwelling and seals off the ventilation.

(5) Waste disposal—Disposal of lead abatement waste and soil must be in compliance with local, state, and federal regulations including sections 22a-209-1, 22a-209-8 (c), 22a-449 (c)-11, and 22a-449 (c)-100 through 22a-449 (c)-110 of the regulations of Connecticut State Agencies.

(d) Soil Areas—Soil areas shall be abated when necessary in a site specific manner as detailed in the lead abatement plan and in accordance with the Connecticut Department of Environmental Protection regulations as noted in section 19a-111-4 (c) (5) of the regulations of Connecticut State Agencies.

(e) Occupancy—Prior to reoccupancy of the abatement area the lead inspector shall ensure through reinspection that the lead abatement plan has been followed and that the following criteria are met.

(1) Every building component upon which removal of lead based surfaces has been performed will be tested using XRF, AAS, GFAAS, or ICP-AES technologies. Successful abatement of these components consists of either meeting the XRF testing criteria defined in 19a-111-3 (a) (1) through 19a-111-3 (a) (3) or by AAS, GFAAS, or ICP-AES analysis of every component abated and determination of a level of lead less than toxic.

(2) Samples of dust shall be collected at the following locations in each room or area

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where lead-based paint has been abated. Additionally, if only a portion of a dwelling unit has been abated, a sample shall be collected from the floor outside the containment within ten (10) feet of the entrance to the abatement area upon completion of abatement activities. Any samples collected under this section shall have lead in dust levels that are below the following clearance criteria for reoccupancy to be allowed:

- (A) floors – 40 mg/sq. ft. (micrograms per square foot);
- (B) window sills – 250 mg/sq. ft.;
- (C) window wells – 400 mg/sq. ft.

(3) When abatement methods of replacement or encapsulation are used in a limited area and very little dust is expected to be generated then clearance dust monitoring may be less than specified in section 19a-111-4 (e) (2) if the alternative dust monitoring is specified in the lead abatement plan.

(f) Letter of Compliance—After lead abatement has been completed in a dwelling unit according to the lead abatement plan and dust levels have been found to be in compliance with section 19a-111-4 (e) (2) of the regulations of Connecticut State Agencies the lead inspector shall issue a letter of compliance within five (5) working days for that dwelling unit stating that the lead inspector has found the dwelling unit free of lead hazards. If intact lead-based surfaces remain then the letter of compliance must state that the lead management plan must be followed to assure compliance with sections 19a-111-1 through 19a-111-11 of the regulations of Connecticut State Agencies.

(Effective September 29, 1992; Amended September 30, 2003)

Sec. 19a-111-5. Time periods for compliance

The local director of health shall ensure that lead abatement projects be completed in a timely fashion according to the time frames specified in the lead abatement plan and according to the following schedule. However, the local director of health may shorten this time table when he/she deems it necessary for prevention of an imminent health hazard.

(a) **Child with an elevated blood lead level**—In a dwelling unit in which a child resides, and has an elevated blood lead level, the owner shall submit a written lead abatement plan to the local director of health within fifteen (15) working days of notification of inspection results. When a property is over 50 years old and is being reviewed for historic status by the Connecticut Historical Commission as required in section 19a-111-3 (g) of the regulations of Connecticut State Agencies, then the owner shall submit a written lead abatement plan to the local director of health within five (5) working days after notification and guidance from the Connecticut Historical Commission is received. The local director of health shall review the plan for completeness and compliance with sections 19a-111-1 through 19a-111-11 of the regulations of Connecticut State Agencies. If the plan is found to be incomplete, the local director of health shall notify the owner in writing within ten (10) working days of receipt of the plan of the reasons why the plan was not complete and establish a time table for compliance. The owner shall initiate abatement of toxic levels of lead within forty-five (45) working days of notification of inspection results and diligently

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pursue such abatement.

(b) **Other dwellings**—In a dwelling in which a child resides, but does not have an elevated blood lead level, the owner shall initiate abatement of all toxic levels of lead in defective condition within ninety (90) working days of notification of the inspection results and diligently pursue such abatement. The owner shall submit a written lead abatement plan to the local director of health within twenty (20) working days of initial identification of a lead hazard. The local director of health shall review the plan for completeness and compliance with sections 19a-111-1 through 19a-111-11 of the regulations of Connecticut State Agencies. If the plan is found to be incomplete, the director of health shall notify the owner in writing within fifteen (15) working days of the reasons why the plan was not approved and establish a time table for compliance.

(Effective September 29, 1992)

Sec. 19a-111-6. Worker protection

(a) **Health monitoring**—The employer shall provide medical examination and monitoring for lead abatement workers.

(1) Information to physicians—The employer shall instruct any examining physician to:

(A) not reveal to the employer any findings unrelated to a worker's occupational exposure to lead;

(B) advise the worker of any medical condition, occupational or nonoccupational, which dictates further medical examination or treatment;

(C) provide the worker with a clear warning of the reproductive and other health hazards of exposure to high levels of lead.

(2) Employment physical—Health monitoring on all lead abatement workers shall include an employment medical examination by a licensed physician which shall consist of:

(A) a work and medical history;

(B) blood pressure measurement;

(C) blood lead level and erythrocyte protoporphyrin level;

(D) complete blood count;

(E) blood urea nitrogen, serum creatinine, routine urinalysis;

(F) other evaluations deemed necessary by the attending physician.

(3) Periodic monitoring—Lead abatement workers shall have blood lead and erythrocyte protoporphyrin tests monthly for the first three (3) months of employment and every three (3) months thereafter.

(4) Physician's report—Within two (2) working days after the receipt of a medical report from the physician the employer shall furnish the applicant with a copy of a written medical report from the physician which contains:

(A) the physician's opinion as to whether the applicant has any detected medical condition which would place the applicant at increased health risk;

(B) any recommended special protective measures to be provided to the applicant, or

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limitations to be placed upon the applicant's exposure to lead;

(C) any recommended limitation upon the applicant's use of respirators.

(b) Management of lead poisoned workers

(1) At blood lead level 25-50 ug/dl the following procedures shall apply.

(A) The attending physician shall report the elevated blood lead level to the individual and to the Department.

(B) The attending physician shall determine if there are symptoms of lead poisoning. If symptoms exist then the provisions of subdivision 19a-111-6 (b) (2) of regulations of Connecticut State Agencies shall be followed.

(C) The attending physician shall contact the affected individual and arrange for repeat blood lead level and erythrocyte protoporphyrin measurement within one (1) month and repeat blood lead level and erythrocyte protoporphyrin measurement until the blood lead level drops below 25 ug/dl.

(D) The attending physician shall notify the employer of the affected individual that this worker has an elevated blood lead level.

(2) In addition to the procedures in subdivision (1) of this subsection, at a blood lead level of greater than 50 ug/dl the following procedures shall also apply.

(A) The attending physician shall arrange for blood lead and erythrocyte protoporphyrin testing every month until the blood lead level drops below 25 ug/dl.

(B) Until the worker's blood lead is less than 50 ug/dl and exhibits no symptoms of lead poisoning, the worker shall be removed from work. The worker may not return to work until a recommendation to start work from the attending physician is received by the worker with a written copy sent to the Department.

(c) Employer responsibility

The employer is responsible for any costs incurred as a result of the health monitoring system.

(d) Personal protective equipment and precautions

(1) The employer shall ensure that all lead abatement workers wear work clothing and protective equipment during the lead abatement procedure. Such clothing shall include but not necessarily be limited to:

(A) when caustic paste is not used as a deleading agent—

(i) coveralls or similar full body covering,

(ii) shoe covers,

(iii) gloves,

(iv) hats,

(v) face shields, vented goggles or other eye protection equipment;

(B) or, when caustic paste is used as a deleading agent—

(i) full-body overalls impervious to caustic substances,

(ii) gloves impervious to caustic substances,

(iii) glove extenders,

(iv) face shield when workers are applying or removing any caustic substance at or above

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face level,

(v) appropriate boot or shoe covers;

(C) respirators approved by the National Institute of Occupational Safety and Health (NIOSH) and the U.S. Department of Labor Mine Safety and Health Administration (MSHA) selected according to the type of abatement process as listed below (or, air monitoring may be used according to OSHA lead standard (29 CFR 1910.1025) to demonstrate which form of respiratory protection is appropriate)—

(i) for use while vacuum sanding with HEPA filter, scraping and with heat guns—powered air-purifying respirator with high efficiency filters, or the half mask supplied-air respirator operated in the positive-pressure mode;

(ii) for use with caustic materials or during abatement involving replacement—half-mask, air-purifying respirator equipped with high efficiency filters;

(iii) for use with a chemical preparation (for example, a solvent) in conjunction with a mechanical or powered technique—an additional cartridge, appropriate to the exposure, unless a supplied-air respirator is used. Any additional cartridge must meet the requirements of the OSHA/MSHA certification for contaminants appropriate to the exposure.

(2) The employer shall:

(A) maintain records on health monitoring tests required on workers for two (2) years;

(B) provide protective clothing in a clean and dry condition daily;

(C) provide for the cleaning, laundering or disposal of protective clothing or equipment;

(D) repair or replace protective equipment as necessary to maintain its effectiveness;

(E) ensure that all protective clothing is removed only in designated change areas at the completion of a work shift;

(F) ensure that contaminated protective clothing which is to be cleaned, laundered or disposed of, is placed in a closed container located in the designated change area which prevents dispersion of lead outside the container;

(G) inform, in writing, any person who cleans or launders protective clothing and equipment of the potentially harmful effects of exposure to lead;

(H) ensure that the containers of contaminated protective clothing and equipment required by these regulations are labeled as follows: CAUTION CLOTHING CONTAMINATED WITH LEAD. DO NOT REMOVE DUST BY BLOWING OR SHAKING. DISPOSE OF LEAD CONTAMINATED WASH WATER IN ACCORDANCE WITH APPLICABLE LOCAL, STATE, AND FEDERAL REGULATIONS;

(I) prohibit the removal of lead from protective clothing or equipment by blowing, shaking or any other means which disperses lead into the air.

(e) **Hygiene facilities and practices**—The employer shall ensure that:

(1) food or beverage is not present or consumed, smoking or chewing of tobacco is not allowed, and cosmetics are not applied in the lead abatement areas;

(2) designated change areas are equipped with separate storage facilities for equipment and protective clothing and for street clothes to prevent contamination with lead;

(3) plastic with a minimum thickness of 6 mils shall cover the walls and floor;

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(4) no person shall exit the changing area to enter the work area unless they are equipped in conformance with subsection 19a-111-6 (d) of the regulations of Connecticut State Agencies;

(5) no contaminated person shall exit this area unless such person has removed their protective clothing, gloves, boot or shoe covers, and respirator;

(6) nor will a person in any other way cause lead contamination to enter the non-work area;

(7) employees do not leave the job site wearing any clothing or equipment, worn during the work shift, that may be contaminated with lead;

(8) employees in lead abatement areas wash their hands prior to eating, drinking, smoking or applying cosmetics.

(Effective September 29, 1992)

Sec. 19a-111-7. Absence of non-workers during abatement

(a) **Residents**—Residents shall not occupy a room or work area where on-site lead paint abatement is occurring. The lead work areas where lead abatement is occurring must be sealed from the remainder of the dwelling according to section 19a-111-4 of the regulations of Connecticut State Agencies.

(b) **Work area**—No person shall enter or remain in a work area at any time during a lead abatement project which involves the on-site removal of lead paint, except for the lead abatement contractor and lead abatement workers, federal, state, and local enforcement officials and their designees, lead inspectors, and the property owner or the owner's designee.

(1) Persons not listed above may enter the work area only after the lead inspector determines that the lead abatement project has been completed in accordance with sections 19a-111-1 through 19a-111-11 of the regulations of Connecticut State Agencies.

(2) All persons present in a work area during a lead abatement project which involves the removal of lead paint shall wear protective equipment as listed in section 19a-111-6 (d) of regulations of Connecticut State Agencies.

(3) At all times when a lead abatement project is being conducted in a common area of a dwelling occupied by two (2) or more dwelling units:

(A) residents shall use alternative entrances and exits which do not require passage through the abatement area, if any such entrance and exit exists;

(B) the lead abatement contractor and lead abatement workers shall use all reasonable efforts to create an uncontaminated passage for all dwelling residents;

(C) in the event that the passage in a building can be reached only through the abatement area, abatement in common areas shall be conducted between the hours of 9 A.M. to 3 P.M. only, and the abatement area shall be thoroughly cleaned with a HEPA vacuum at the end of each working day;

(D) all building unit and fire code requirements for access to a dwelling must be maintained for occupied dwellings. If containment required for lead abatement blocks

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access, then affected dwelling units must be vacated during blockage.

(Effective September 29, 1992)

Sec. 19a-111-8. Reports to the commissioner

In addition to notification of inspection reports required under subsection 19a-111-3 (d) of regulations of Connecticut State Agencies, local code enforcement agencies shall submit a report to the commissioner, on a form prescribed by the commissioner by the 15th day of January, April, July, and October for the previous quarter signed by the head of such agency. This report shall list:

- (a) the medical status of all lead poisoned children,
- (b) all uncorrected violations at the end of the previous quarter,
- (c) all violations corrected during the previous quarter, and
- (d) what legal action has been taken regarding each uncorrected violation.

(Effective September 29, 1992)

Sec. 19a-111-9—19a-111-10. Repealed

Repealed November 29, 1995.

Sec. 19a-111-11. Severability

If any provision of Sections 19a-111-1 through 19a-111-11 inclusive of the regulations of Connecticut State Agencies shall be held inconsistent with federal laws or the laws of the State of Connecticut, that inconsistency shall not affect the remaining provisions.

(Effective September 29, 1992)

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Department of Health Services

Subject

Requiring Lifeguards to be Certified in Cardiopulmonary Resuscitation

Section

§ 19a-113a-1

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Sec. 19a-113a-1.	Requirement for lifeguards to be certified in cardiopulmonary resuscitation
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Requiring Lifeguards to be Certified in Cardiopulmonary Resuscitation

Sec. 19a-113a-1. Requirement for lifeguards to be certified in cardiopulmonary resuscitation

(a) **Definitions.** As used in this section:

(1) “Certified” means currently recognized as a trained practitioner of a skill.

(2) “Employed” means used in a capacity of responsibility, whether for financial remuneration or as a volunteer.

(3) “Face mask or shield” means a device constructed so as to prevent the return flow of air from a victim to the rescuer.

(4) “Lifeguard” means the person employed at the waterfront who has responsibility for the safety and well-being of persons at a pool, beach, or other swimming facility.

(b) Persons who are employed as lifeguards shall be certified in cardiopulmonary resuscitation by the American Heart Association or the American Red Cross.

(c) **Cardiopulmonary resuscitation certification**—for purposes of this section cardiopulmonary resuscitation certification shall include at least the following components:

(1) Methods for clearing the obstructed airway.

(2) One rescuer adult cardiopulmonary resuscitation.

(3) Two rescuer adult cardiopulmonary resuscitation.

(4) Infant small child cardiopulmonary resuscitation.

(d) Each facility employing lifeguards shall provide infant, child, and adult face masks or shields and shall provide appropriate receptacles or holders in proximity to the lifeguard duty stations.

(Effective March 7, 1989)

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Subject

Medical Test Units

Inclusive Sections

§§ 19a-115-1—19a-115-6

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Sec. 19a-115-1—19a-115-6. Repealed

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Medical Test Units

Sec. 19a-115-1—19a-115-6. Repealed

Repealed October 7, 2008.

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Subject

Regulations on Abortions

Section

§ 19a-116-1

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Sec. 19a-116-1. Abortion services in outpatient clinics

Regulations on Abortions

Sec. 19a-116-1. Abortion services in outpatient clinics

Outpatient clinics which offer abortion services shall comply with sections 19-13-D45 through 19-13-D54 of the Regulations of Connecticut State Agencies and in addition thereto, shall comply with the following provisions:

(a) Facilities, equipment and care shall be consistent with the national standards of the American College of Obstetrics and Gynecology.

(b) Any women seeking an abortion shall be given:

(1) Verification of the diagnosis and duration of pregnancy, including preoperative history and physical examination;

(2) Information and an explanation of the procedure to be followed in accordance with subsection (c) of this section;

(3) Counseling about her decision;

(4) Laboratory tests, including blood grouping and Rh factor;

(5) Preventive therapy if at risk for Rh sensitization;

(6) Examination of tissue by a pathologist;

(7) Consultation as to the need for follow-up care;

(8) Information on family planning;

(9) A written discharge summary which indicates the patient's status and discharge plan, signed by both the patient and a licensed or certified health care provider, a copy of which shall be given to the patient and a copy shall be retained as part of the medical record; and

(10) Information regarding access to her medical record, which shall include a statement of patient confidentiality and the requirement for written consent for release of information to persons not otherwise authorized by law to access the record.

(c) **Informed consent.** Prior to performing an abortion, a counselor shall obtain informed consent from the woman seeking to have the abortion. Informed consent shall exist only when a consent form is completed voluntarily and in accordance with the following provisions:

(1) An individual who obtains informed consent from a woman for an abortion procedure shall:

(A) Offer to answer any questions the patient may have concerning the procedure;

(B) Provide a copy of the informed consent form to the patient as described in subdivision (2) of this subsection;

(C) Provide all of the following information orally to the patient:

(i) A thorough explanation of the procedures to be performed; and

(ii) A full description of the discomforts and risks that may accompany or follow the performance of the procedure; and

(D) Assure the patient that an interpreter is provided to assist the patient if she does not understand the language used on the consent form or the language used by the counselor obtaining consent.

(2) Consent form requirements

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(A) A consent form shall clearly spell out in language the patient can understand the nature and consequences of the procedure which shall be used.

(B) The consent form shall be signed and dated by:

- (i) the patient;
- (ii) the interpreter, if one is provided;
- (iii) the counselor who obtains the consent; and
- (iv) the physician who will perform the procedure.

(d) **Staff qualifications**

(1) All counselors in an abortion clinic shall have background preparation in social work, psychology, counseling, nursing, or ministry. Such preparation shall have been obtained in formal course work or through in-service staff training.

(2) Those counselors who do not have a graduate degree in any of the above mentioned fields shall be supervised by a person with such a graduate degree. Such supervision shall consist of the direction, inspection, and on-site observation of the activities of the counselors in performance of their duties.

(e) **Quality assurance and risk management.** All abortion clinics shall implement a written quality assurance and risk management program which shall include but not necessarily be limited to the following components:

- (1) annual program objectives and evaluation;
- (2) quarterly clinical record review;
- (3) annual documentation of clinical competence of professional staff; and
- (4) annual outcome audits.

(f) **Emergency preparedness.** Each clinic shall formulate and implement when necessary a plan for the safety of the patients in the event of fire, natural and other disasters, and bomb threat.

(1) Fire. A written plan shall include but not necessarily be limited to:

- (A) posted fire evacuation plans in prominent areas showing two evacuation routes;
- (B) fire drills conducted at unexpected times, at least quarterly on each shift;
- (C) a written record of each fire drill including date, time, personnel in attendance and evaluation;
- (D) tasks and responsibilities assigned to all personnel; and,
- (E) an annual review and acceptance of the plan by the local fire marshal.

(2) Natural and other disasters. A written plan shall include but not necessarily be limited to:

- (A) policies for internal and external disasters;
 - (B) notification of designated persons;
 - (C) orderly patient removal and relocation if required;
 - (D) accountability of patients and staff during evacuation; and
 - (E) patient notification in the event of an interruption in services.
- (3) Bomb threat. A written plan shall include but not necessarily be limited to:
- (A) collection of all information from the caller by the recipient of the call;

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- (B) notification of emergency and administrative personnel;
- (C) total communication and coordination between emergency and facility personnel;
- (D) responsibilities of all staff during bomb threat;
- (E) orderly patient removal and relocation if required; and
- (f) accountability of patients and staff during evacuation.

(Effective August 1, 1983; Amended December 30, 1996)

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Subject

Allocation of AIDS Funds

Inclusive Sections

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Sec. 19a-121b-1.	Funding (Repealed)
Sec. 19a-121b-2.	HIV testing (Repealed)
Sec. 19a-121b-3.	Commissioner's requests for proposals (Repealed)
Sec. 19a-121b-4—19a-121b-6.	Repealed
Sec. 19a-121b-7.	Repealed

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Allocation of AIDS Funds

Sec. 19a-121b-1. Funding (Repealed)

Repealed June 11, 2014.

(Effective May 2, 1988; Amended December 8, 2008; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-121b-2. HIV testing (Repealed)

Repealed June 11, 2014.

(Effective May 2, 1988; Amended December 8, 2008; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-121b-3. Commissioner's requests for proposals (Repealed)

Repealed June 11, 2014.

(Effective May 2, 1988; Amended December 8, 2008; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-121b-4—19a-121b-6. Repealed

Repealed December 8, 2008.

Sec. 19a-121b-7. Repealed

Repealed June 11, 2014.

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

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Subject

Adverse Event Reporting for Hospitals and Outpatient Surgical Facilities

Inclusive Sections

§§ 19a-127n-1—19a-127n-2

CONTENTS

Sec. 19a-127n-1.	Definitions
Sec. 19a-127n-2.	Procedures for adverse event reporting

Adverse Event Reporting for Hospitals and Outpatient Surgical Facilities

Sec. 19a-127n-1. Definitions

As used in section 19a-127n-1 to section 19a-127n-2, inclusive of the Regulations of the Connecticut State Agencies:

(1) “Adverse event” means “adverse event” as defined in section 19a-127n of the Connecticut General Statutes;

(2) “Commissioner” means the commissioner of the Department of Public Health;

(3) “Corrective action plan” means “corrective action plan” as defined in section 19a-127n of the Connecticut General Statutes;

(4) “Department” means the Department of Public Health;

(5) “Disability” means a physical or mental impairment that substantially limits one or more of the major life activities of an individual;

(6) “Emergent report” means the report of an unexpected situation or sudden occurrence of a serious and urgent nature which requires immediate remedial action on the part of the facility to protect the health and safety of its patient population, or an event which is unusually serious in nature and has resulted in a patient’s death or injury. Emergent reports shall include but are not limited to: abduction of a patient of any age, sexual assault on a patient, patient death associated with the use of restraints and all fires;

(7) “Facility” means any hospital or outpatient surgical facility licensed pursuant to section 19a-490 of the Connecticut General Statutes;

(8) “Immediate plan of action” means immediate actions taken by the facility to reduce the risk of a similar event occurring until the long-term preventive strategies can be determined and implemented;

(9) “Off campus satellite sites” means health care and service delivery sites that would require a separate institutional license in accordance with Connecticut General Statutes section 19a-490 but for the fact that these entities are incorporated within the hospital’s single license; and

(10) “Serious” means an event that results in death or loss of a body part, disability or loss of bodily function lasting more than seven days or still present at the time of discharge from an inpatient facility.

(Adopted effective October 29, 2007)

Sec. 19a-127n-2. Procedures for adverse event reporting

(a) All adverse events shall be documented by the facility and submitted to the department. All documentation of adverse events shall be maintained at the facility for not less than three (3) years.

(b) All adverse events identified in the National Quality Forum’s list of serious events, as amended, and those on the list compiled by the department, as amended, shall be reported by the facility on the adverse event reporting form prescribed by the Commissioner.

(c) Reports: A hospital or outpatient surgical facility shall report an adverse event to the department as follows:

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(1) An adverse event deemed to be emergent by the facility shall be reported immediately by telephone and confirmed by written report not later than seven (7) days after the occurrence of said event; and

(2) An adverse event not deemed to be emergent by the facility shall be submitted in writing not later than seven (7) days after the occurrence of the event.

(d) Emergent adverse event telephone notification shall include the following:

(1) Date and time of occurrence;

(2) Name and phone number of the facility's contact person;

(3) Name and address of the hospital or outpatient surgical facility;

(4) The number assigned to the adverse event report; and

(5) A brief description of the emergent adverse event.

(e) Each written adverse event report shall contain the following information:

(1) Demographic data for all facilities

(A) Facility information: type of facility, facility name and address, license number, reporter's name, contact person's name and telephone number; and

(B) Patient information: medical record number, age, sex, date of admission, patient's billing number, date and time of event, date and time event first known, date of patient death, if applicable, and patient admission diagnosis;

(2) Demographic data for hospitals only

(A) Inpatient: hospital based, off campus satellite site-name and address; or

(B) Outpatient: hospital based, off campus satellite site-name and address; and

(C) Location of occurrence within the site;

(3) Notifications: Indicate whether notification of the event was provided to the patient or to any other entity listed in the adverse event reporting form;

(4) Description of event from list of required reportable adverse events;

(5) Facts of event and patient condition; and

(6) Immediate plan of action, which shall include the immediate care provided to the patient as well as the immediate actions taken by the facility to reduce the risk of a similar event occurring until the long-term preventive strategies can be determined and implemented.

(f) A corrective action plan shall be submitted to the department not later than thirty (30) days after the occurrence of the adverse event.

(g) Each corrective action plan shall include the following information:

(1) Facility name;

(2) Report number;

(3) Patient billing number;

(4) Date plan submitted;

(5) Event being addressed;

(6) Findings of facility investigation;

(7) Corrective action plan: Following the facility investigation, each corrective action plan shall address a prospective plan to reduce the risk of the occurrence of a similar adverse

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Department of Public Health

§19a-127n-2

event and shall include but not be limited to the following information:

(A) How other patients having the potential to be affected by a similar event will be identified;

(B) Identification of long term strategies to be implemented to prevent subsequent occurrences;

(C) Mechanisms for monitoring the implementation of the components of the corrective action plan;

(D) Root cause analysis determination;

(E) Timeline for implementation of the corrective action plan;

(F) Completion date for the corrective action plan;

(G) Identification of the staff member, by title, who will monitor the implementation of the corrective action plan;

(H) Name of person submitting the corrective action plan; and

(I) Date the corrective action plan was signed.

(h) Numbering: Each adverse event report shall be identified on each page with a number as follows:

(1) The number appearing in the facility license;

(2) The last two digits of the year; and

(3) The sequential number assigned to the report for the calendar year.

(i) The department's list of reportable adverse events includes:

(1) Perforations during open, laparoscopic and/or endoscopic procedures resulting in death or serious disability;

(2) Obstetrical events resulting in death or serious disability to the neonate;

(3) Significant medication reactions resulting in death or serious disability;

(4) Laboratory or radiologic test results not reported to the treating practitioner or reported incorrectly which result in death or serious disability due to incorrect or missed diagnosis in the emergency department; and

(5) Nosocomial infections defined as reportable sentinel events by the Joint Commission on Accreditation of Healthcare Organizations.

(Adopted effective October 29, 2007; Amended December 4, 2009)

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Agency

Office of Health Care Access

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Transferred to Sec. 19a-643-1, February 26, 1999

Sec. 19a-160-2. Transferred

Transferred to Sec. 19a-643-2, February 26, 1999

Sec. 19a-160-3. Transferred

Transferred to Sec. 19a-643-3, February 26, 1999

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Transferred to Sec. 19a-643-4, February 26, 1999

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Transferred to Sec. 19a-643-8, February 26, 1999

Sec. 19a-160-12. Transferred

Transferred to Sec. 19a-643-10, February 26, 1999

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Transferred to Sec. 19a-643-23, February 26, 1999

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Repealed April 20, 1990.

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Repealed April 20, 1990.

Sec. 19a-160-24. Transferred

Transferred to Sec. 19a-643-29, February 26, 1999

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Sec. 19a-160-27. Transferred

Transferred to Sec. 19a-643-32, February 26, 1999

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Sec. 19a-160-30. Transferred

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Sec. 19a-160-37. Transferred

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Transferred to Sec. 19a-643-51, February 26, 1999

Sec. 19a-160-41. Transferred

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Sec. 19a-160-42. Transferred

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Sec. 19a-160-44. Transferred

Transferred to Sec. 19a-643-64, February 26, 1999

Sec. 19a-160-45. Transferred

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Transferred to Sec. 19a-643-102, February 26, 1999

Sec. 19a-160-55. Transferred

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Sec. 19a-160-64. Transferred

Transferred to Sec. 19a-643-78, February 26, 1999

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Transferred to Sec. 19a-643-79, February 26, 1999

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Transferred to Sec. 19a-643-85, February 26, 1999

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Transferred to Sec. 19a-643-86, February 26, 1999

Sec. 19a-160-70. Repealed

Repealed December 17, 1984.

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Sec. 19a-160-71—19a-160-78. Repealed

Repealed February 26, 1999.

Sec. 19a-160-79. Transferred

Transferred to Sec. 19a-643-75, February 26, 1999

Sec. 19a-160-80. Repealed

Repealed February 26, 1999.

**Rates to be Charged by Home Health Care, and Homemaker Home Health Aide
Agencies**

Sec. 19a-160-81—19a-160-87. Repealed

Repealed February 26, 1999.

**Establishment of an Expedited Hearing Process for the Review of Certain Capital
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Sec. 19a-160-88. Transferred

Transferred to Sec. 19a-643-94, February 26, 1999

Sec. 19a-160-89. Transferred

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Transferred to Sec. 19a-643-111—19a-643-115, February 26, 1999

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Sec. 19a-160-100. General purpose (Repealed)

Repealed June 11, 2014.

(Effective August 23, 1984; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-160-101. Definitions (Repealed)

Repealed June 11, 2014.

(Effective December 17, 1984; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-160-102. Proposed operating and capital expenditures budgets (Repealed)

Repealed June 11, 2014.

(Effective August 23, 1984; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-160-103. General approach—operating budget (Repealed)

Repealed June 11, 2014.

(Effective August 23, 1984; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-160-104. Overall test of reasonableness (Repealed)

Repealed June 11, 2014.

(Effective August 23, 1984; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-160-105. Presumptively reasonable CY (budget base) (Repealed)

Repealed June 11, 2014.

(Effective August 23, 1984; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-160-106. Budget base selection (Repealed)

Repealed June 11, 2014.

(Effective August 23, 1984; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

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Sec. 19a-160-107. Inflation factor (Repealed)

Repealed June 11, 2014.

(Effective August 23, 1984; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-160-108. Changes due to volume (BY v CY) (Repealed)

Repealed June 11, 2014.

(Effective August 23, 1984; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-160-109. Funding of depreciation (Repealed)

Repealed June 11, 2014.

(Effective August 23, 1984; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-160-110. Interest, operating leases (Repealed)

Repealed June 11, 2014.

(Effective August 23, 1984; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-160-111. Non-volume (Repealed)

Repealed June 11, 2014.

(Effective August 23, 1984; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-160-112. Working capital and bad debts (Repealed)

Repealed June 11, 2014.

(Effective August 23, 1984; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-160-113. Free care and settlement allowance (Repealed)

Repealed June 11, 2014.

(Effective August 23, 1984; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

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Sec. 19a-160-114. Non-operating revenues (Repealed)

Repealed June 11, 2014.

(Effective August 23, 1984; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-160-115. Capital expenditure budgets (Repealed)

Repealed June 11, 2014.

(Effective August 23, 1984; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-160-116. Compliance (Repealed)

Repealed June 11, 2014.

(Effective August 23, 1984; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-160-117. Public hearing: budget modification (Repealed)

Repealed June 11, 2014.

(Effective December 17, 1984; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-160-118. Interim adjustments (Repealed)

Repealed June 11, 2014.

(Effective August 23, 1984; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-160-119. Annual reporting to the commission (Repealed)

Repealed June 11, 2014.

(Effective February 24, 1988; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-160-120. Transferred

Transferred to Sec. 19a-643-25, February 26, 1999

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Sec. 19a-160-130—19a-160-138. Repealed

Repealed February 26, 1999.

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Repealed February 26, 1999.

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Sec. 19a-165q-100—19a-165q-108. Repealed

Repealed February 26, 1999.

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Commission on Hospitals and Health Care

§

Negotiation of Discounts with Hospitals

Sec. 19a-166-1. Definitions (Repealed)

Repealed June 11, 2014.

(Effective March 12, 1986; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-166-2. Prompt payment and administrative services discounts (Repealed)

Repealed June 11, 2014.

(Effective March 12, 1986; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-166-3. Additional blue cross discounts (Repealed)

Repealed June 11, 2014.

(Effective March 12, 1986; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-166-4. Eligible organization discounts (Repealed)

Repealed June 11, 2014.

(Effective March 12, 1986; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-166-5. Other discounts (Repealed)

Repealed June 11, 2014.

(Effective March 12, 1986; Repealed June 11, 2014)

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

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Agency

Office of Health Care Access

Subject

FY 1990 Hospital Budget Review

Inclusive Sections

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Sec. 19a-167g-1—19a-167g-50. Repealed

Repealed February 26, 1999.

FY 1991 and Subsequent Years Hospital Budget Review

Sec. 19a-167g-51. Transferred

Transferred to Sec. 19-a-643-200., November 1, 2007

Sec. 19a-167g-52. Transferred

Transferred to Sec. 19a-643-202., November 1, 2007

Sec. 19a-167g-53. Reserved (Repealed)

Repealed June 11, 2014.

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-167g-54. Transferred

Transferred to Sec. 19a-643-203., November 1, 2007

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Transferred to Sec. 19a-643-201., November 1, 2007

Sec. 19a-167g-56—19a-167g-68. Repealed

Repealed November 1, 2007.

Sec. 19a-167g-69. Reserved (Repealed)

Repealed June 11, 2014.

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-167g-70. Repealed

Repealed November 1, 2007.

Sec. 19a-167g-71. Reserved (Repealed)

Repealed June 11, 2014.

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-167g-72—19a-167g-73. Repealed

Repealed November 1, 2007.

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Sec. 19a-167g-74—19a-167g-80. Reserved (Repealed)

Repealed June 11, 2014.

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-167g-81—19a-167g-82. Repealed

Repealed November 1, 2007.

Sec. 19a-167g-83—19a-167g-89. Reserved (Repealed)

Repealed June 11, 2014.

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-167g-90. Transferred

Transferred to Sec. 19a-643-204., November 1, 2007

Sec. 19a-167g-91. Transferred

Transferred to Sec. 19a-643-206., November 1, 2007

Sec. 19a-167g-92. Reserved (Repealed)

Repealed June 11, 2014.

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

Sec. 19a-167g-93. Repealed

Repealed November 1, 2007.

Sec. 19a-167g-94. The uniform reporting of discharge abstract and billing data

For the purpose of sections 3, 4, 5, 8, 12, 18, and 29 of public act 89-371, and section 11 of public act 90-134, the following section shall be used to report discharge abstract and billing data in fiscal year 1991 and thereafter. The provisions of this section shall supersede the provisions of 19a-165q-2 of the integrated prospective payment system regulations.

(a) **Definitions.** For the purpose of this section and except as otherwise noted, the following words and phrases are defined below:

(1) “Agent” means a person or entity which has entered into an agreement or contract with the commission to perform administrative, processing, management, analytical, evaluative, or other related services with the data collected pursuant to this section.

(2) “Current hospitalization” or “hospitalization being recorded” refers to that episode of hospitalization defined by the patient’s admission and discharge dates and the medical record number and patient control number associated with that episode. All the data being submitted by the hospital concerning the patient’s hospitalization relate to this episode of hospitalization.

(3) “Discharge” is defined according to subdivision 19a-167g-55 (b) (22).

(4) “Patient identification” means the unique designation or number assigned to each

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patient within a hospital that distinguishes by itself the medical record of an individual patient from the medical record of all other patients in that institution.

(5) “Patient control number” means the unique designation or number assigned by the hospital to each patient’s individual hospitalization that distinguishes by itself the medical and billing records of that hospitalization.

(6) “Date of birth” means the month, day, and year on which the patient whose hospitalization is being recorded was born.

(7) “Date of admission” means the month, day, and year on which the patient whose hospitalization is being recorded was admitted to the hospital.

(8) “Date of discharge” means the month, day, and year on which the patient whose hospitalization is being recorded was discharged from the hospital.

(9) “Sex” means a designation of the patient as:

<u>designation</u>	<u>code</u>
(A) Male	=M
(B) Female	=F
(C) Not determined	=U

The category “not determined” may only be used in rare instances where the sex of the patient either has not been or cannot be determined at the time of discharge.

(10) “Zip code” means the zip code of the post office where the patient customarily receives mail. If the patient resides outside the United States or its territories, the zip code shall be “99998.”

(11) “Race” means a designation of the patient according to the categories listed below. For the purpose of reporting this information to the commission as part of this data set, each category is assigned the numeric codes listed below:

<u>category</u>	<u>code</u>
(A) White	=1
(B) Black	=2
(C) American Indian/Eskimo/Aleut	=3
(D) Hawaiian/Pacific Islander	=4
(E) Asian	=5
(F) Other Non-white	=6
(G) Unknown	=0

(12) “Ethnicity” refers to the patient’s cultural origin. The patient must be classified into one of the categories of ethnicity listed below. For the purpose of reporting this information to the commission as part of this data set, each ethnic category is assigned the numeric codes listed below:

<u>category</u>	<u>code</u>
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- | | |
|-------------------------------------|----|
| (A) Spanish origin/Hispanic | =1 |
| (B) Non-Spanish origin/Non-Hispanic | =2 |

(13) “Previous admission” refers to the length of time between the date of admission for the hospitalization being recorded and the date of discharge for the patient’s most recent previous inpatient hospitalization. For the purpose of reporting this information to the commission as part of this data set, the categories of previous admission are assigned the numeric codes listed below:

<u>category</u>	<u>code</u>
(A) Less than 31 days	=1
(B) More than 30 but less than 61 days	=2
(C) More than 60 but less than 91 days	=3
(D) More than 90 but less than 181 days	=4
(E) More than 180 days	=5
(F) No previous hospitalization	=6
(G) Unknown	=7

(14) “Hospital ID code” refers to the last four digits of the hospital’s Medicare provider number for the unit from which the patient was discharged for the hospitalization being recorded.

(15) “Attending practitioner” means the physician, surgeon, homeopath, dentist, podiatrist, chiropractor, osteopath, or psychologist who was primarily responsible for the patient’s care during the hospitalization being recorded. The attending practitioner will be designated by the hospital using the unique code established pursuant to subsection (e) of this section.

(16) “Operating practitioner” means the physician, surgeon, homeopath, dentist, podiatrist, chiropractor, osteopath, or psychologist who performed the principal procedure during the hospitalization being recorded. The operating practitioner will be designated by the hospital using the unique code established pursuant to subsection (e) of this section.

(17) “Principal diagnosis and secondary diagnoses” refer to diagnoses that affect the hospitalization being recorded.

(A) “Principal diagnosis” refers to the condition which is established after study to be chiefly responsible for the admission of the patient to the hospital.

(B) “Secondary diagnoses” refers to those conditions, exclusive of the principal diagnosis, which exist at the time of the patient’s admission or which develop subsequently to the admission and which affect the patient’s treatment or length of stay for the hospitalization being recorded. Diagnoses which are associated with an earlier hospitalization and which have no bearing on the current hospitalization shall not be recorded as secondary diagnoses.

(18) Procedures and procedure days.

(A) “Procedure” means a significant procedure that is surgical in nature; carries a

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procedural or anesthetic risk; or requires specialized training or special facilities or equipment.

(B) “Procedure day” refers to the day on which the procedure was performed. The procedure day equals the number of days after the admission date on which the procedure was performed. If the procedure was performed on the date of admission, then the procedure day = 0.

(C) “Principal procedure” means that procedure most closely related to the principal diagnosis which is performed for the definitive treatment of the patient.

(i) The principal procedure cannot be a procedure which has been performed for a diagnostic or exploratory purpose only or to resolve a complication, unless these are the only types of procedures performed on the patient during the hospitalization being recorded.

(ii) “Complication” is defined in this section as any diagnosis other than the principal diagnosis.

(D) “Other procedures” means other significant procedures in addition to the principal procedure. These are to be reported with the procedure day on which the procedure was performed.

(19) “Admission status” describes the circumstances associated with the patient’s admission and will be limited to the following:

<u>circumstance</u>	<u>code</u>
(A) Physician Referral	1
(B) Clinic Referral	2
(C) HMO Referral	3
(D) Transfer from a Hospital	4
(E) Transfer from a Skilled nursing facility	5
(F) Transfer from another health care facility	6
(G) Emergency room	7
(H) Court/law enforcement	8
(I) Newborn	9

(20) “Discharge status” means a designation associated with the circumstances of the patient’s discharge and will be limited to the following:

<u>designation</u>	<u>code</u>
(A) Home	01
(B) Transferred to another short term hospital	02
(C) Transferred to a skilled nursing facility	03
(D) Transferred to an intermediate care facility	04
(E) Transferred to another type of institution	05
(F) Discharged to home health service	06

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(G) Left against medical advice	07
(H) Expired	20

(21) “Expected principal source of payment” means that payment source that was expected at the time the data set was completed to provide the primary share of the payment for the hospitalization being recorded. These sources will be limited to the following:

<u>payment source</u>	<u>code</u>
(A) Self pay	A
(B) Worker’s Compensation	B
(C) Medicare	C
(D) Medicaid	D
(E) Other Federal Program	E
(F) Commercial Insurance Company	F
(G) Blue Cross	G
(H) CHAMPUS	H
(I) Other	I
(J) Title V	Q
(K) No Charge	R
(L) HMO	S
(M) PPO	T

(22) “CHAMPUS” is defined in 19a-167g-55 (b) (13).

(23) “Title V” means the Maternal and Child Health Services Block Grant as provided under Title V of the Social Security Act.

(24) “HMO” and “PPO” refer to alternative delivery systems and are defined in 19a-167g-55 (b) (3).

(25) “Birthweight” means the weight in grams of a newborn infant recorded at birth. This value must be coded if the admission status is newborn.

(26) “Total revenue center charges” means the total charges appearing on the patient’s bill. This amount should correspond to revenue code “001” on a standard UB-82 bill.

(27) A “group of revenue data elements” means an individual, distinct revenue code and its corresponding units of service and charges for the hospitalization being recorded. One group of revenue data elements consists of the revenue center code, its units of service, and its total charges.

(28) “UB-82 data” refers to those uniform billing data elements generated by hospitals for the purpose of billing hospital charges to patients for services rendered after September 30, 1984. These data elements are contained on a “UB-82 form” which is that version of the Uniform Hospital Billing Form promulgated by the National Uniform Billing Committee, established by the American Hospital Association, as from time to time amended. The UB-82 form has also been adopted as Health Care Financing Administration

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(HCFA) Form 1450 pursuant to Sections 1814 (a) (1) and 1871 of the federal Social Security Act.

(29) “Discharge abstract” refers to those items of medical and demographic information which are normally available in the patient’s medical record and which may be abstracted from that medical record as data elements. The discharge abstract for the hospitalization being recorded summarizes the important clinical features of that patient’s hospitalization. For the purpose of this section, the items of medical and demographic information referred to by the term “discharge abstract data” are data elements numbered 4, 6–12, 14–15, 17–18 on record type 2, items numbered 4, 6–14 on record type 3, and items numbered 4, 6–8, 10–11, 13–14, 16–17, 19–20, and 22–23 on record type 4 of subsection (h) (8), below. Some of these items may also be found on the patient’s UB-82 billing form. These data elements may also be part of the UB-82 data.

(30) A “test tape” is defined as the submission of a sample of a hospital’s discharge abstract and billing data set as part of the initial submission of data pursuant to subsection (b) (5) or for the purpose of testing technical changes made by the hospital which affect the submission of its discharge abstract and billing data set on computer tape. The test tape shall conform exactly to all the technical specifications provided for in this section. The sample of the data set contained on a hospital’s test tape shall not exceed one-twelfth (1/12) of that hospital’s total discharges for fiscal year 1989.

(31) Reports.

(A) A “report” is defined as data or information extracted or prepared from the data collected under this section or section 19a-165q-2 of the commission’s regulations. This includes data derived from other sources when such data are combined with the data collected under this section. The report may be presented in any form, either on paper or contained in computer-accessible files on-or offline on magnetic media, such as magnetic tapes, disks, or drums.

(B) If a report, either by itself or in combination with another report, can identify an individual patient or practitioner either by personal identification code, by name, or by a combination of data elements, then it will be considered “confidential.”

(C) If a report, either by itself or in combination with another report, cannot identify an individual patient or practitioner either by personal identification code, by name, or by a combination of data elements, then it will be considered “nonconfidential.”

(32) “Data element” means an individual category of data taken from a discharge’s medical record or hospital bill (UB-82 data). Data elements to be filed pursuant to this section are prescribed in subsection (h) (9), and, when appropriate, are defined in subsection (a).

(33) “Data record” refers to a 282-byte array of a computer file containing data elements specific to a hospital or to individual discharges from a hospital. Six types of data records shall be filed by a hospital pursuant to this section. They are referred to as data record type 1 through data record type 6. These data record types are described in subsections (h) (4) and (h) (9).

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(34) “Data set” refers to the complete set of data records filed by a hospital for a reporting period. The data set shall contain the discharge abstract and billing data for each individual discharged from that hospital during the reporting period. The data set shall be composed of one header record (data record type 1), one trailer record (data record type 6) for each hospital, and a group of data records (data record types 2 through 5, inclusive) for each individual discharged from that hospital. These data records shall include the data elements prescribed in subsection (h) (9).

(35) “Payer identification” means the code number or the payer name which identifies the payer organization from which the hospital expects at the time of discharge some payment for the bill. Up to three payer organizations shall be reported in order of their expected contributions to the payment of the hospital bill.

(36) “Estimated responsibility” means the amount estimated by the hospital at the time of discharge to be paid by the indicated payer.

(37) “Deductible” means that amount estimated by the hospital at the time of discharge to be applied to the patient’s deductible amount for the indicated payer.

(38) “Coinsurance” means that amount estimated by the hospital at the time of discharge to be applied to the patient’s coinsurance amount for the indicated payer.

(39) A “report cell” means the intersection of a row and column of data elements in a report.

(b) Filing Requirements and Filing Periods.

(1) Before the end of each calendar quarter after September 30, 1990, each hospital shall file with the commission or its agent a complete discharge abstract and billing data set, as specified in subsection (h).

(2) This data set shall contain the data records for each individual discharged from that hospital during the preceding calendar quarter. The data set for a calendar quarter shall be filed prior to the end of the calendar quarter following the calendar quarter in which the discharges whose data are contained therein occurred. For example, the data set to be filed before March 31, 1991, shall contain the data records for each individual discharged from that hospital from October 1, 1990, until December 31, 1990. Nothing in this section is intended to alter the data filing requirements of section 19a-167g-42. Data for the calendar quarter July 1, 1990 through September 30, 1990 continues to be due the commission under section 19a-167g-42.

(3) For its first submission pursuant to this section, the hospital shall file a test tape pursuant to subsection (b) (5).

(4) Ninety (90) days prior to the end of the filing periods specified in subsection (b) (1), the commission shall notify the hospital of any supplemental instructions for submission of the hospital discharge abstract and billing data set.

(5) Submission of test tapes.

(A) The initial submission of discharge abstract and billing data sets under this section is due before April 1, 1991. As part of that submission, a hospital shall submit a test tape for its data set. Thereafter, when a change in the instructions or specifications for the

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submission of the hospital discharge abstract and billing data set occurs which requires a modification of the submission format of the data set, hospitals may submit up to three test tapes to verify that they have implemented the format changes correctly.

(B) The first test tape must be submitted within ninety (90) days following the first day of the fiscal quarter in which the specification changes are required to be initiated.

(C) The commission's agent will process the test tapes upon receipt, accept or reject the test tapes based upon their conformance to the specifications required, and notify each hospital or their designated data vendor with a written evaluation of each test tape.

(D) If a hospital's test tape is accepted by the agent, no additional test tapes will be processed by the agent for that hospital. If the hospital's test tape is rejected by the agent, the hospital shall submit a revised test tape for reevaluation within fifteen (15) business days of the hospital's or data vendor's receipt of the agent's evaluation of its rejected test tape.

(E) The submission of test tapes does not, in itself, exempt a hospital from the filing requirements of subsections (b) (1) and (b) (2).

(F) A hospital will not be considered to have violated the provisions of subsection (b) (2) if it has adhered to the testing schedule described in subsections (b) (5) (B) through (b) (5) (D) and has not submitted more than three test tapes.

(G) If any hospital requests the submission of a test tape for any reason other than those specified in (b) (5) (A), or if a hospital is required to submit more than three test tapes for any filing period, then the cost of processing the additional test tapes shall be borne by the hospital.

(6) Exemptions to the filing requirements.

(A) A hospital may be granted a partial, temporary exemption from filing those data elements specified in (6) (F) if the data elements cannot be provided to the commission in a timely manner by the hospital.

(B) The commission shall grant an exemption provided the hospital applies for it and the commission finds that the application demonstrates sufficient grounds for the exemption.

(C) Specifically, if the hospital is not collecting the specified data elements on or about October 1, 1990, and cannot begin collecting them on that date due to computer software or data collection forms which do not provide for their collection, and the hospital's application sufficiently supports this claim, then the hospital shall be granted a partial exemption for those data elements until such time as the commission deems appropriate.

(D) The application for exemption shall contain at least the following materials:

(i) A statement of which data elements cannot be provided in a timely manner and why they cannot be provided.

(ii) Samples of the hospital's discharge abstract and UB-82 data element collection forms or other data element collection instruments with effective dates on or about October 1, 1990.

(iii) Sworn statements from the hospital's data processing vendor(s) and/or data processing manager stating that the hospital cannot provide the data elements to the

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commission in a timely manner and why it cannot.

(iv) The earliest date on which the hospital expects to provide the data elements to the commission.

(v) Any other supporting documentation considered relevant to the hospital's application by the hospital or the commission.

(E) The exemption shall be partial and until such time as the commission determines is reasonably required for the hospital to comply.

(F) The following data elements may be exempted from the filing requirements of this section until such date as the commission may deem appropriate, but no later than October 1, 1991: ethnicity, previous admission, secondary diagnosis 5, secondary diagnosis 6, secondary diagnosis 7, secondary diagnosis 8, secondary diagnosis 9, other procedure 5, other procedure 5 day, other procedure 6, other procedure 6 day, other procedure 7, other procedure 7 day, other procedure 8, other procedure 8 day, other procedure 9, other procedure 9 day, birthweight, payer identification 1, payer identification 2, payer identification 3. In addition, the data element race may be partially exempted, so that a hospital which receives such an exemption shall be required to collect that data element as required by the regulations in effect during fiscal year 1990.

(G) The following data elements shall be exempted from the filing requirements of this section until October 1, 1991: estimated responsibility 1, deductible 1, coinsurance 1, estimated responsibility 2, deductible 2, coinsurance 2, estimated responsibility 3, deductible 3, and coinsurance 3.

(H) Hospitals not granted an exemption by the commission shall begin gathering the specified data elements in their required formats, as prescribed in subsections (a) and (h), on October 1, 1990, for initial submission to the commission on April 1, 1991.

(7) Hospitals may request an extension of the filing periods in this section pursuant to section 19a-160-16 of the commission's regulations.

(c) **Billing data.** As provided in subsection (h), the hospital shall report the detailed charges for each discharge in a group of data records that are already merged with the discharge abstract data elements. The charges shall be reported in detail, itemized by individual three-digit UB-82 revenue code in a manner consistent with the reporting of the charge data elements on the UB-82 form.

(d) **Standards for data; notification; response.**

(1) Each discharge abstract and billing data set submitted by a hospital for patients discharged after September 30, 1990, shall be evaluated by the commission or its agent according to the following standards:

(A) For each data set submitted by a hospital, the values or codes for any data element within an individual discharge's data records shall be valid values or codes or contained within valid ranges of values for the data element. Invalid codes or values will be rejected as errors. Data elements and their valid values or codes are specified in subsections (a) and (h). Invalid codes are specified in subsection (h) (10).

(B) Those data elements which are related to other data elements within an individual

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discharge's data records must be internally consistent in substantive content or they will be rejected as errors. Edits to be applied for consistency are specified in subsection (h) (11).

(C) Coding values indicating "data not available," "data unknown," or any other such value or term indicating that the valid code, value, or range of values for particular data elements is not available will not be accepted for individual data items. Submission of such values for data elements will be rejected as errors.

(D) Any discharge which is assigned to DRG 469 or 470 after grouping by the version of the Medicare grouper valid for the period in which the patient is discharged shall be rejected as an error. The hospital shall review the medical record for such discharge and modify the discharge data set accordingly so that the discharge is correctly assigned to a DRG other than 469 or 470.

(2) Upon completion of this evaluation, the commission or its agent shall promptly notify each hospital whose data sets do not satisfy the standards for any filing period. This notification shall identify the discharge abstract or billing data elements for any discharge which are in error, suspected of being in error, or otherwise do not satisfy the standards.

(A) This notification will specify the problematic data elements.

(B) Error documentation and correction procedures will be provided to each hospital with each notification.

(3) Each hospital notified pursuant to subsection (d) (2) shall make the changes necessary to correct the errors and satisfy the standards and submit these changes to the commission or its agent within 30 days of the notification.

(e) Central registry for practitioner codes.

(1) All practitioners who provide services at a hospital within the state must be registered with the commission by means of a central registry.

(2) The registry will contain the practitioner's name, address, birthdate, state health department license number, any other information as may be required by the commission to uniquely distinguish the practitioner from any other practitioner providing services in the state, and an identification number which uniquely distinguishes the practitioner from any other practitioner providing services in the state.

(3) The commission designates the Connecticut Health Care Provider Billing Identification System (CHCPBIS) to be the central registry specified in subsection (1), above, and the CHCPBIS provider code number to be the identification number which the hospitals shall use for the attending and operating practitioner data elements described in (a) (15) and (a) (16), respectively. As designee, the CHCPBIS shall provide the information specified in subsection (e) (2) to the commission on a regular and timely basis.

(4) Should the designee cease to maintain this registry or fail to provide the specified information to the commission on a regular and timely basis, the commission shall declare the designation made in subsection (3) void. In this case, the identification number provided by the hospitals for the attending and operating practitioner data elements should be that practitioner code required by the Health Care Financing Administration (HCFA) in its administration of the Medicare Program.

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(5) Should HCFA cease to require a unique practitioner identifier for the Medicare program, then each hospital shall be responsible for providing the commission or its agent with the practitioner's name, current address, birthdate, and state health department license number or such other information as may be required by the commission to uniquely distinguish each practitioner from any other practitioner providing services in the state as new practitioners begin providing services to the hospital. Upon receipt of this information, the commission or its agent will assign each practitioner his or her own unique identification number.

(f) Noncompliance.

(1) Except as specified in subsection (f) (2), the failure to file, report or correct the discharge abstract or billing data sets according to the provisions of this section shall be considered a violation of public act 89-371 and these regulations. Any hospital determined by the commission to have violated the provisions of this section shall be subject to the provisions of Section 19a-160-120 of the commission's regulations and any other remedies or penalties available to the commission.

(2) A hospital which files discharge abstract and billing data sets which do not satisfy the standards under subsection (d) of this section shall not be considered in violation of these regulations if:

(A) the hospital corrects all such data sets as specified in subsection (d) (3) of this section; or

(B) the number of individual discharges whose data records fail to meet the standards for the filing period does not exceed one percent of the total number of individual discharges required to be filed in that period.

(g) Maintenance of confidentiality.

(1) Only such data as are relevant and necessary to implement public acts 89-371 and 90-134 will be collected by the commission.

(2) All data collected under this section of these regulations will be maintained accurately and diligently.

(3) Only such members of the commission, its attorney, agents, or their employees who have a specific need to review discharge and billing data collected pursuant to this section or confidential reports prepared from such data will be entitled to access to such data or reports.

(4) The commission, its attorney, agents, or their employees who are involved in the administration, management, processing, analysis, or other use of the discharge abstract and billing data shall not make public any confidential reports.

(5) The following data elements are confidential and shall not be released to the public: patient identification number, patient control number, date of birth, date of admission, date of discharge, attending practitioner, and operating practitioner.

(6) Notwithstanding the provision of subsection (g) (4), nonconfidential reports from which individual patient and practitioner data cannot be identified shall be made available to the public.

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(7) Data elements and suppression thresholds for nonconfidential reports.

(A) To create a nonconfidential report, the following data elements collected under this section will be replaced by substitute data elements which have been modified for purposes of confidentiality as follows:

(i) Birthdate will be replaced by age group. Age groups shall contain age ranges of no less than five years and must be compatible with those released by the U.S. Census Bureau. All ages greater than 90 years will be included in the same group.

(ii) Date of discharge will be replaced by fiscal quarter and year of discharge.

(iii) Admission date and discharge date will be replaced by average length of stay in aggregate reports and length of stay in other nonconfidential reports.

(iv) Zip code will be replaced by an aggregation of zip codes composed of at least two contiguous zip codes and subject to the provisions of subsection (7) (B).

(v) Birthweight will be replaced by birthweight group. Each birthweight group shall contain birthweight ranges of no less than 500 grams. These ranges must end in even hundred grams (e.g. 2,001–2,500 grams).

(vi) Payer identification will be aggregated to only those payer categories specified in subsection (a) (21), Expected Principal Source of Payment.

(vii) All billing data elements related to patient charges will be replaced by the corresponding average charges in aggregate reports.

(B) Thresholds for data suppression for nonconfidential reports.

(i) Except for average length of stay and average charges, a nonconfidential, aggregated report shall not contain information or data based on fewer than six individual patients, as defined by the patient identification number, in a single report cell. In the case of average length of stay and average charges, if the average is based on fewer than six patients, the number of patients upon which it is based will not be released.

(ii) Except for average length of stay and average charges, a nonconfidential, aggregated report shall not contain information or data based on fewer than two individual practitioners, as defined by the attending or operating practitioner codes, in a single report cell.

(iii) An aggregated report shall not contain the payer data elements “estimated responsibility,” “deductible,” and “coinsurance” if the values of these data elements are based on fewer than two individual payers, as defined by the payer identification codes, in a single report cell.

(iv) Any nonaggregated report which contains data elements by discharge shall not contain the data element “hospital code,” and shall contain a substitute for the data element “zip code.” This substitute shall be composed of an aggregation of zip codes equivalent to the health service areas created pursuant to the National Health Planning and Resources Development Act, Public Law 93-641.

(C) Combinations of all other data elements not restricted by subsections (g) (4), (g) (5), and (g) (7) may be released in nonconfidential reports.

(8) Procedures for requesting, producing, and releasing nonconfidential reports.

(A) All reports under consideration by the commission for public release shall be

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considered confidential until determined to be nonconfidential by the process described in this subsection.

(B) Requests for any data collected under this section must be made in writing to the chairman of the commission. The request shall contain a list of the data elements being sought, a detailed description of the content and organization of any report and an example of the report's layout showing how the data will be organized and presented. It shall also contain a statement by the requestor confirming that the request conforms to the confidentiality provisions of this subsection.

(C) A designated commissioner shall review the request and respond within four business days as follows:

(i) A request which seeks data elements deemed confidential by subsection (g) (7) (A) or which does not meet the thresholds of subsection (g) (7) (B) shall be denied within four (4) business days.

(ii) A request for data from which it can be readily determined from the face of the request that an individual patient or physician cannot be identified and that the request conforms to (g) (7) (A) and (g) (7) (B) will be approved for preparation. The requestor will be notified of such approval within four (4) business days. The requestor shall assume the cost of preparing a requested report not already in existence. Such cost may be required to be paid in whole or in part prior to the preparation of the report.

(iii) A request for data from which it cannot be readily determined whether an individual patient or physician can be identified or whether the request conforms to (g) (7) (A) and (g) (7) (B) will be subjected to the procedure set forth in (E) below prior to a determination by a commissioner that the request will be approved for preparation. The requestor shall be notified within four (4) business days that the request will undergo such a procedure.

(D) All requests for data will be publicly noticed as an addendum to the commission's calendar. This notice will contain the name of the requestor and the general nature of the request. If the request identifies the data as that of an individually identified hospital, the commission will notify the hospital at this time that a request for data collected pursuant to this section has been filed. Any person may obtain a copy of such request on application to the commission. Any person may raise concerns about whether the requested report conforms to the confidentiality requirements of this subsection but the raising of any concerns shall not toll any determination by a designated commissioner whether to approve or deny a request except as set forth in (E) below.

(E) for requests which fall under subsection (g) (8) (C) (iii), any person may raise concerns about whether the requested report conforms to the confidentiality requirements of this subsection provided he or she does so in writing within ten (10) business days of the public notice given under (D). Any concerns will be considered by the designated commissioner before the request is approved for preparation.

(i) A designated commissioner shall review such request. If the commissioner determines that such request conforms to the confidentiality requirements of this subsection, the request may be approved for preparation. The requestor shall assume the cost of preparing a

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requested report not already in existence. Such cost may be required to be paid in whole or in part prior to the preparation of the report.

(F) When prepared, a copy of the report will be reviewed by the designated commissioner for conformity to the confidentiality requirements of this subsection. If the report conforms to these requirements, it shall be authorized for release.

(G) The commission retains ownership rights to all data used in the report and will retain a copy of the final report. Nonconfidential reports approved for release will thereafter be available for copying by members of the public other than the original requestor.

(H) The commission will maintain a record of all approved requests for reports. The record will be available to the public on request. This record will contain the name of the person or party making the request, the nature of the request, and the date the request was approved for release.

(I) The commission reserves the right to refuse any request for a report which could threaten the confidentiality of an individual patient or practitioner.

(9) The commission shall ensure that any contract into which it enters with an agent using confidential data collected under this section shall contain provisions requiring the agent to comply with the provisions of this subsection. The commission, not its agent, is the sole owner of the data collected under this section. No agent may release any data or report whatsoever, whether confidential or not, to any person or party, unless authorized in writing by the commission in accordance with this section.

(10) Security of the discharge abstract and billing data.

(A) The commission shall ensure that steps are taken to control access to any confidential data collected under this section or reports developed from these data. These steps shall include the use of information systems software and other security procedures designed to protect against unauthorized access. These security procedures shall be available to the public.

(B) Any agent of the commission must provide a detailed description of its data security provisions and the policies and procedures it will employ to ensure the security and confidentiality of the data collected under this section.

(C) To the greatest extent practicable, confidential reports maintained at the commission will be kept in controlled access areas. Confidential reports will be kept in locked files when not in use. Confidential reports maintained on the commission's computer system will be stored in limited-access directories. Documents containing confidential reports will be clearly labeled as confidential.

(11) The commission, its attorney, agents, and any of their employees who are involved in the collection, maintenance, analysis, or other use of the discharge abstract and billing data, will be informed of the policies and procedures contained in subsections (g) (1) through (g) (10) regarding the maintenance and use of these data.

(h) **Specifications for the submission of the discharge abstract and billing data sets.**

(1) Each hospital shall file with the commission or its agent a complete discharge abstract and billing data set on magnetic computer tape containing data records for each patient

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discharged from the hospital after September 30, 1990. The data records for each discharge shall contain complete discharge abstract and billing data for all the data elements specified in subsection (h) (9). When reported, the discharge abstract and billing data elements for each discharge shall already be merged into a single set of data records for that discharge, as prescribed in subsections (h) (2) (A) through (h) (2) (C).

(2) The organization of data records within a data set.

(A) For each discharge, the data elements to be filed shall be contained on one type 2 data record, one type 3 data record, one type 4 data record, and one or more type 5 data records. This means that multiple data records shall be filed for each discharge.

(B) The type 2 data record shall contain the discharge's demographic information. The type 3 data record shall contain the discharge's diagnostic information. The type 4 data record shall contain the discharge's procedural information. The type 5 data record(s) shall contain the discharge's revenue or billing information.

(C) All record types for an individual discharge shall follow one another immediately in sequence beginning with the type 2 data record for that discharge. Each discharge must have one type 2 data record followed by one type 3 data record, one type 4 data record, and at least one type 5 data record, in that order. For data record type 5, the sequence number shall reflect the order of appearance of type 5 records for an individual discharge.

(D) A type 1 data record must never immediately follow another type 1 data record. A type 2 data record for a given discharge must never immediately follow a type 2 data record for a different discharge.

(E) Each hospital shall submit a single header data record, data record type 1, and a single trailer data record, data record type 6, which will enclose the data records for all discharges contained in any submission, if more than one hospital's data set is submitted on a single tape, each hospital's data set shall be delimited by its own type 1 and type 6 data records.

(3) Rules for coding revenue data elements.

(A) The billing (or revenue) data elements shall be reported in a manner consistent with the reporting of UB-82 revenue data elements. Each revenue code for which the discharge has accrued charges must be reported along with the total charges corresponding to that revenue code. For each revenue code between 020 through 219, inclusive, for which the discharge has accrued charges, units of service corresponding to that revenue code must be reported.

(B) Revenue codes shall be reported to the third digit. Each charge must correspond to a valid UB-82 revenue code. Revenue codes must be acceptable values in the range between 020–999, inclusive, that appear in the UB-82 billing manual, maintained by the Connecticut UB-82 billing committee. Total units of service and total charges corresponding to the individual revenue codes for the hospitalization being recorded are to be reported as they are reported on the UB-82 form.

(C) Each type 5 data record can hold up to 18 groups of revenue data elements (i.e. revenue code, units of service by revenue code, and charges by revenue code). No blanks

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shall occur prior to the end of the last group of data elements for the last revenue code. Unused space for revenue data elements in the last or only type 5 data record must be zero filled.

(D) There shall be only one occurrence of a unique revenue code on each discharge's set of type 5 data records. This means that charges and units must be aggregated to the revenue code level.

(4) Rules for diagnosis and procedure coding.

(A) Principal and secondary diagnoses shall be recorded according to the conventions governing the coding of diagnoses contained in the most current version of the International Classification of Diseases, 9th Revision, Clinical Modification ('ICD-9-CM').

(B) Diagnoses shall be coded in the most specific category available for that diagnosis at the time of discharge. A diagnosis may not be assigned a less specific code if a more specific code is available for that diagnosis.

(C) The diagnosis codes must be legitimate, lowest-level, ICD-9-CM codes with decimal points omitted. Diagnosis codes shall be entered as a 5-digit code even though there may only be 3 or 4 significant digits. Decimal points are to be implied, not explicit. This means that all digits in the code must be entered, including leading and trailing zeros. If the lowest-level code for a diagnosis has only three or four significant digits, including leading and trailing zeros, blanks must be entered in positions 4 and/or 5 if necessary.

(D) The first four secondary diagnoses recorded shall be consistent with those contained on the discharge's UB-82 bill for the hospitalization being recorded. The remaining five diagnoses shall be taken from either the discharge's UB-82 bill or the discharge abstract. If, for the hospitalization being recorded, a discharge has nine or more unique secondary diagnoses on either the UB-82 bill or the discharge abstract, then the hospital must report nine secondary diagnoses on the data record. If a discharge has fewer than nine unique secondary diagnoses on both the UB-82 bill and the discharge abstract, then the unused space reserved for the additional diagnoses shall be blank filled.

(E) The reporting of procedure codes shall follow the same rules as those outlined for diagnosis codes in (A) through (C), above, except that the procedure codes shall be entered as a 4-digit instead of a 5-digit code. Procedure codes shall be entered as a 4-digit code even though there may only be 2 or 3 significant digits. The codes entered must be legitimate lowest level ICD-9-CM codes except that decimal points are to be implied, not explicit. This means that leading and trailing zeros must be entered and blanks must be entered in positions 3 and/or 4 if necessary. Other procedure fields are to be blank filled if not applicable.

(F) The first two other procedures shall be consistent with those contained on the discharge's UB-82 bill for the hospitalization being recorded. The remaining seven procedures shall be taken from either the discharge's UB-82 bill or the discharge abstract.

(G) If a discharge has nine or more unique other procedures on either the UB-82 bill or the discharge abstract for the hospitalization being recorded, then the hospital must report nine other procedures on the data record. If a discharge has fewer than nine other procedures

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on both the UB-82 bill and the discharge abstract for the hospitalization being recorded, then the unused space reserved for the additional procedures shall be blank filled.

(H) For each procedure reported, the day on which the procedure was performed relative to the day of admission must also be reported. Procedures performed on day of admission shall reflect a procedure day of "000." Procedure day fields are to be blank filled if no corresponding procedure is recorded.

(I) If a procedure has been reported to diagnose or treat a complication, as defined in subsection (a) (12) (B) (ii), then the complication must be reported as a secondary diagnosis.

(5) Regarding the coding of admission status, if the discharge was admitted through the emergency room after having been transferred from any other health care facility, then this admission may not be coded as an emergency room admission.

(6) Regarding the coding of payer identification, follow UB-82 instructions for completing the data field specified in (h) (9), including the use of the three-digit carrier code if the primary payer is a commercial carrier. Precede the three digit code by two zeros to completely fill the five-character, alpha-numeric field. Enter the expected primary payer as payer identification 1, and other payers as payer identification 2 and payer identification 3.

(7) Regarding the coding of estimated responsibility, deductible, and coinsurance, follow UB-82 instructions for completing these data fields for each payer identification. Enter the values of these data elements for the expected primary payer as estimated responsibility 1, deductible 1, and coinsurance 1, respectively, and the values of these data elements for other payers as estimated responsibility 2, deductible 2, and coinsurance 2, and estimated responsibility 3, deductible 3, and coinsurance 3, respectively.

(8) Magnetic Tape Specifications.

<u>(A) Characteristics</u>	<u>Specifications</u>
1. Number of tracks	9 track
2. Parity	Odd
3. Label type	OS Standard Labels or Nonlabeled
4. Density	1,600 BPI or 6,250 BPI
5. Character Code	EBCDIC
6. Record Format	Fixed-Length, Fixed-Blocked
7. Record Length	282 bytes
8. Records per Block	113
9. Block Size	31,866 Bytes

(B) The logical data record length shall be 282 and the blocking factor shall be equal to 113. Therefore, the blocksize equals 31,866.

(C) The submission of a magnetic tape requires a Standard Tape Submittal Form, in all cases.

(D) The standard tape submittal form, which must always be used, must be supplemented

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by an attached document, as applicable, which clearly identifies the tape contents as to the reporting period submitted for each hospital.

(E) Each tape can contain data sets from one or more hospitals as long as each hospital's data records are preceded by a Header Data Record (data record type 1) and followed by a Trailer Data Record (data record type 6), as specified in subsections (h) (2) and (H) (9). The hospital data set can include data from one or more quarters within one fiscal year; data from multiple fiscal years cannot be mixed on one tape.

(9) Record layout and format.

#Data Element Description	Format	Bytes	Start	Stop	Reference	#Instruction
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Data Record Type 1: Data Set Header Record

1 Record Type Indicator	9(2)	2	1	2	—	8
2 Filler	X(2)	2	3	4	—	—
3 Hospital ID code	X(4)	4	5	8	Definitions	1,3
4 Hospital Name	X(40)	40	9	48	—	1,3
5 Processing Date	9(8)	8	49	56	—	7
6 Period Start Date	9(8)	8	57	64	—	7
7 Period End Date	9(8)	8	65	72	—	7
8 Filler	X(210)	210	73	282	—	—

Data Record Type 2: Demographic Data Record

1 Record Type Indicator	9(2)	2	1	2	—	8
2 Filler	X(2)	2	3	4	—	—
3 Hospital ID code	X(4)	4	5	8	Definitions	1,3
4 Patient Identification Number	X(20)	20	9	28	Definitions	1,3
5 Patient Control Number	X(20)	20	29	48	Definitions	1,3
6 Date of Birth	9(8)	8	49	56	Definitions	7
7 Date of Admission	9(8)	8	57	64	Definitions	7
8 Date of Discharge	9(8)	8	65	72	Definitions	7
9 Sex	X(1)	1	73	73	Definitions	—
10 Race	9(1)	1	74	74	Definitions	—
11 Ethnicity	9(1)	1	75	75	Definitions	—
12 Zip Code	X(5)	5	76	80	Definitions	1,3
13 Filler	X(4)	4	81	84	—	—
14 Admission Status	9(1)	1	85	85	Definitions	2,4
15 Discharge Status	9(2)	2	86	87	Definitions	2,4

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16 Birthweight	9(4)	4	88	91	Definitions	2,4
17 Previous Admission	9(1)	1	92	92	Definitions	—
18 Principal Payment Source	X(1)	1	93	93	Definitions	1,3
19 Payer Identification 1	X(5)	5	94	98	Definitions	2,4
20 Estimated Responsibility 1	9(6)	6	99	104	Definitions	2,4,9
21 Deductible 1	9(6)	6	105	110	Definitions	2,4,9
22 Coinsurance 1	9(6)	6	111	116	Definitions	2,4,9
23 Payer Identification 2	X(5)	5	117	121	Definitions	2,4
24 Estimated Responsibility 2	9(6)	6	122	127	Definitions	2,4,9
25 Deductible 2	9(6)	6	128	133	Definitions	2,4,9
26 Coinsurance 2	9(6)	6	134	139	Definitions	2,4,9
27 Payer Identification 3	X(5)	5	140	144	Definitions	2,4
28 Estimated Responsibility 3	9(6)	6	145	150	Definitions	2,4,9
29 Deductible 3	9(6)	6	151	156	Definitions	2,4,9
30 Coinsurance 3	9(6)	6	157	162	Definitions	2,4,9
31 Revenue Center Code 001	9(3)	3	163	165		2,4
32 Total Routine Units of Service	9(4)	4	166	169		2,4
33 Total Detailed Charges	9(8)	8	170	177		2,4,9
34 Filler	X(105)	105	178	282	—	—
Data Record Type 3: Diagnosis Data Record						
1 Record Type Indicator	9(2)	2	1	2	—	8
2 Filler	X(2)	2	3	4	—	—
3 Hospital ID code	X(4)	4	5	8	Definitions	1,3
4 Patient Identification Number	X(20)	20	9	28	Definitions	1,3
5 Patient Control Number	X(20)	20	29	48	Definitions	1,3
6 Attending physician	X(9)	9	49	57	Definitions	1,3
7 Principal diagnosis	X(5)	5	58	62	ICD-9-CM	1,3,5,6
8 Secondary diagnosis 1	X(5)	5	63	67	ICD-9-CM	1,3,5,6
9 Secondary diagnosis 2	X(5)	5	68	72	ICD-9-CM	1,3,5,6

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10 Secondary diagnosis 3	X(5)	5	73	77	ICD-9-CM	1,3,5,6
11 Secondary diagnosis 4	X(5)	5	78	82	ICD-9-CM	1,3,5,6
12 Secondary diagnosis 5	X(5)	5	83	87	ICD-9-CM	1,3,5,6
13 Secondary diagnosis 6	X(5)	5	88	92	ICD-9-CM	1,3,5,6
14 Secondary diagnosis 7	X(5)	5	93	97	ICD-9-CM	1,3,5,6
15 Secondary diagnosis 8	X(5)	5	98	102	ICD-9-CM	1,3,5,6
16 Secondary diagnosis 9	X(5)	5	103	107	ICD-9-CM	1,3,5,6
17 Filler	X(175)	175	108	282	—	—

Data Record Type 4: Procedure Data Record

1 Record Type Indicator	9(2)	2	1	2	—	8
2 Filler	X(2)	2	3	4	—	—
3 Hospital ID code	X(4)	4	5	8	Definitions	1,3
4 Patient Identification Number	X(20)	20	9	28	Definitions	1,3
5 Patient Control Number	X(20)	20	29	48	Definitions	1,3
6 Operating physician	X(9)	9	49	57	Definitions	1,3
7 Principal procedure	X(4)	4	58	61	ICD-9-CM	1,3,5
8 Principal proc. day	9(3)	3	62	64	Definitions	2,3
9 Filler	X(9)	9	65	73	—	—
10 Other procedure 1	X(4)	4	74	77	ICD-9-CM	1,3,5
11 Other proc. 1 day	9(3)	3	78	80	Definitions	2,3
12 Filler	X(9)	9	81	89	—	—
13 Other procedure 2	X(4)	4	90	93	ICD-9-CM	1,3,5
14 Other proc. 2 day	9(3)	3	94	96	Definitions	2,3
15 Filler	X(9)	9	97	105	—	—
16 Other procedure 3	X(4)	4	106	109	ICD-9-CM	1,3,5
17 Other proc. 3 day	9(3)	3	110	112	Definitions	2,3
18 Filler	X(9)	9	113	121	—	—
19 Other procedure 4	X(4)	4	122	125	ICD-9-CM	1,3,5
20 Other proc. 4 day	9(3)	3	126	128	Definitions	2,3
21 Filler	X(9)	9	129	137	—	—
22 Other procedure 5	X(4)	4	138	141	ICD-9-CM	1,3,5
23 Other proc. 5 day	9(3)	3	142	144	Definitions	2,3
24 Filler	X(9)	9	145	153	—	—

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25 Other procedure 6	X(4)	4	154	157	ICD-9-CM	1,3,5
26 Other proc. 6 day	9(3)	3	158	160	Definitions	2,3
27 Filler	X(9)	9	161	169	—	—
28 Other procedure 7	X(4)	4	170	173	ICD-9-CM	1,3,5
29 Other proc. 7 day	9(3)	3	174	176	Definitions	2,3
30 Filler	X(9)	9	177	185	—	—
31 Other procedure 8	X(4)	4	186	189	ICD-9-CM	1,3,5
32 Other proc. 8 day	9(3)	3	190	192	Definitions	2,3
33 Filler	X(9)	9	193	201	—	—
34 Other procedure 9	X(4)	4	202	205	ICD-9-CM	1,3,5
35 Other proc. 9 day	9(3)	3	206	208	Definitions	2,3
36 Filler	X(74)	74	209	282	—	—

Data Record Type 5: Billing Data Record(s)

1 Record Type Indicator	9(2)	2	1	2	—	8
2 Record Sequence Number	9(2)	2	3	4	(h) (2) (C)	2,4,10
3 Hospital ID code	X(4)	4	5	8	Definitions	1,3
4 Patient Identification Number	X(20)	20	9	28	Definitions	1,3
5 Patient Control Number	X(20)	20	29	48	Definitions	1,3
6 Revenue Code #1	9(3)	3	49	51	UB-82 Manual	2,4
7 Units of Service by Revenue Code #1	9(4)	4	52	55	UB-82 Manual	2,4
8 Charges by Revenue Code #1	9(6)	6	56	61	UB-82 Manual	2,4,9
9 Revenue Code #2	9(3)	3	62	64	UB-82 Manual	2,4
10 Units of Service by Revenue Code #2	9(4)	4	65	68	UB-82 Manual	2,4
11 Charges by Revenue Code #2	9(6)	6	69	74	UB-82 Manual	2,4,9
12 Revenue Code #3	9(3)	3	75	77	UB-82 Manual	2,4
13 Units of Service by Revenue Code #3	9(4)	4	78	81	UB-82 Manual	2,4

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14 Charges by Revenue Code #3	9(6)	6	82	87	UB-82 Manual	2,4,9
15 Revenue Code #4	9(3)	3	88	90	UB-82 Manual	2,4
16 Units of Service by Revenue Code #4	9(4)	4	91	94	UB-82 Manual	2,4
17 Charges by Revenue Code #4	9(6)	6	95	100	UB-82 Manual	2,4,9
18 Revenue Code #5	9(3)	3	101	103	UB-82 Manual	2,4
19 Units of Service by Revenue Code #5	9(4)	4	104	107	UB-82 Manual	2,4
20 Charges by Revenue Code #5	9(6)	6	108	113	UB-82 Manual	2,4,9
21 Revenue Code #6	9(3)	3	114	116	UB-82 Manual	2,4
22 Units of Service by Revenue Code #6	9(4)	4	117	120	UB-82 Manual	2,4
23 Charges by Revenue Code #6	9(6)	6	121	126	UB-82 Manual	2,4,9
24 Revenue Code #7	9(3)	3	127	129	UB-82 Manual	2,4
25 Units of Service by Revenue Code #7	9(4)	4	130	133	UB-82 Manual	2,4
26 Charges by Revenue Code #7	9(6)	6	134	139	UB-82 Manual	2,4,9
27 Revenue Code #8	9(3)	3	140	142	UB-82 Manual	2,4
28 Units of Service by Revenue Code #8	9(4)	4	143	146	UB-82 Manual	2,4
29 Charges by Revenue Code #8	9(6)	6	147	152	UB-82 Manual	2,4,9
30 Revenue Code #9	9(3)	3	153	155	UB-82 Manual	2,4
31 Units of Service by Revenue Code #9	9(4)	4	156	159	UB-82 Manual	2,4
32 Charges by Revenue	9(6)	6	160	165	UB-82	2,4,9

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Code #9					Manual		
33 Revenue Code #10	9(3)	3	166	168	UB-82 Manual	2,4	
34 Units of Service by Revenue Code #10	9(4)	4	169	172	UB-82 Manual	2,4	
35 Charges by Revenue Code #10	9(6)	6	173	178	UB-82 Manual	2,4,9	
36 Revenue Code #11	9(3)	3	179	181	UB-82 Manual	2,4	
37 Units of Service by Revenue Code #11	9(4)	4	182	185	UB-82 Manual	2,4	
38 Charges by Revenue Code #11	9(6)	6	186	191	UB-82 Manual	2,4,9	
39 Revenue Code #12	9(3)	3	192	194	UB-82 Manual	2,4	
40 Units of Service by Revenue Code #12	9(4)	4	195	198	UB-82 Manual	2,4	
41 Charges by Revenue Code #12	9(6)	6	199	204	UB-82 Manual	2,4,9	
42 Revenue Code #13	9(3)	3	205	207	UB-82 Manual	2,4	
43 Units of Service by Revenue Code #13	9(4)	4	208	211	UB-82 Manual	2,4	
44 Charges by Revenue Code #13	9(6)	6	212	217	UB-82 Manual	2,4,9	
45 Revenue Code #14	9(3)	3	218	220	UB-82 Manual	2,4	
46 Units of Service by Revenue Code #14	9(4)	4	221	224	UB-82 Manual	2,4	
47 Charges by Revenue Code #14	9(6)	6	225	230	UB-82 Manual	2,4,9	
48 Revenue Code #15	9(3)	3	231	233	UB-82 Manual	2,4	
49 Units of Service by Revenue Code #15	9(4)	4	234	237	UB-82 Manual	2,4	
50 Charges by Revenue Code #15	9(6)	6	238	243	UB-82 Manual	2,4,9	

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51 Revenue Code #16	9(3)	3	244	246	UB-82 Manual	2,4
52 Units of Service by Revenue Code #16	9(4)	4	247	250	UB-82 Manual	2,4
53 Charges by Revenue Code #16	9(6)	6	251	256	UB-82 Manual	2,4,9
54 Revenue Code #17	9(3)	3	257	259	UB-82 Manual	2,4
55 Units of Service by Revenue Code #17	9(4)	4	260	263	UB-82 Manual	2,4
56 Charges by Revenue Code #17	9(6)	6	264	269	UB-82 Manual	2,4,9
57 Revenue Code #18	9(3)	3	270	272	UB-82 Manual	2,4
58 Units of Service by Revenue Code #18	9(4)	4	273	276	UB-82 Manual	2,4
59 Charges by Revenue Code #18	9(6)	6	277	282	UB-82 Manual	2,4,9

Data Record Type 6: Data Set Trailer Record

1 Record Type Indicator	9(2)	2	1	2	—	8
2 Filler	X(2)	2	3	4	—	—
3 Hospital ID code	X(4)	4	5	8	Definitions	1,3
4 Total Hospital Discharges	9(6)	6	9	14	—	2,4,11
5 Total Hospital Patient-Days	9(9)	9	15	23	—	2,4,11
6 Total Hospital Charges	9(9)	9	24	32	—	2,4,9,11
7 Filler	X(250)	250	33	282	—	—

Instruction Codes:

1. Left justified.
2. Right justified.
3. Fill all open bytes with blank.
4. Fill all open bytes with zero.
5. Must be valid, lowest level ICD-9-CM code excluding decimal points; decimal implied according to the ICD-9-CM system. (XXX.XX for diagnoses; XX.XX for procedures)
6. For ICD-9-CM codes using “E” or “V,” “E” or “V” should be located in left-most position within field.
7. The format to be used for dates is YYYYMMDD.

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8. The values for the Data Record Type Indicators shall be coded as follows:

Data Record Type 1 =01, Data Record Type 2 =02,
Data Record Type 3 =03, Data Record Type 4 =04,
Data Record Type 5 =05, Data Record Type 6 =06.

9. Enter values for this data element as a whole dollar amount. Round the actual value contained on the discharge's bill to the nearest whole dollar amount.

10. For Data Record Type 5, the sequence number shall reflect the order of appearance of Type 5 data records for each discharge. The sequence number for a discharge's first Type 5 data record equals 01; the sequence number for a discharge's second Type 5 data record equals 02; the sequence number for a discharge's third Type 5 data record equals 03; and so on.

11. Total hospital discharges shall equal the total number of patients discharged from the hospital during the reporting period and shall equal the total number of Type 2 data records filed in the hospital's data set. Total hospital patient days shall equal the sum of the lengths of stay for all hospital patients discharged from the hospital during the reporting period. Total hospital charges shall equal the total charges billed to all hospital patients discharged from the hospital during the reporting period.

(10) Required characteristics for the discharge and billing data elements.

(A) Invalid values for data fields.

Number	Fieldname	Invalid Field Coding
1.	Patient Identification	All zeros; all spaces; all nines
2.	Patient Control Number	All zeros; all spaces; all nines
3.	Date of Birth	Non-numeric data
4.	Date of Admission	Non-numeric data; invalid year
5.	Date of Discharge	Non-numeric data; invalid year
6.	Previous Admission	Non-numeric data; all zeros
7.	Patient Sex	Any designation code not found in definitions
8.	Race	Non-numeric data; any designation code not found in definitions
9.	Ethnicity	Non-numeric data; any designation code not found in definitions
10.	Patient Zip Code	Non-numeric data; all zeros
11.	Hospital ID Code	Any designation code not found in definitions
12.	Attending Practitioner No.	All zeros; all spaces; all nines; any code

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		not found on the Connecticut Health Care Provider Identification List
13.	Operating Practitioner No.	All zeros; all nines; any code not found on the Connecticut Health Care Provider Identification List
14.	Principal Diagnosis Code	All spaces; first digit is E; invalid ICD-9-CM diagnosis code
15.	Secondary Diagnosis Codes	Missing Principal Diagnosis Code; invalid ICD-9-CM diagnosis code
16.	Principal Procedure	Invalid ICD-9-CM procedure code
17.	Principal Procedure Day	Non-numeric data; number exceeding length-of-stay
18.	Other Procedures	Invalid ICD-9-CM procedure code; missing Principal Procedure
19.	Other Procedure Days	Non-numeric data; number exceeding length-of-stay
20.	Admission Status	Non-numeric data; any designation code not found in definitions
21.	Discharge Status	Non-numeric data; any designation code not found in definitions
22.	Expected Principal Source of Payment	Any designation code not found in definitions
23.	Birthweight	Non-numeric data
24.	Payer Identification	Any designation code not found in UB-82 Manual; non-numeric data
25.	Estimated Responsibility	Non-numeric data
26.	Deductible	Non-numeric data
27.	Coinsurance	Non-numeric data
28.	Total Actual Charges	Non-numeric data; all detail charges missing; total not in agreement with sum of individual detail charges
29.	Revenue Codes	Valid UB-82 revenue center codes between 001 and 999
30.	Revenue Code Units of Service	Non-numeric data
31.	Detailed Revenue Code Charges	Non-numeric data

(B) The following edits from the Medicare Code Editor will be applied to the data. Data

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elements failing these edits will be rejected as errors.

- (i) Invalid diagnosis or procedure code
- (ii) Invalid fourth or fifth digit
- (iii) E-code as principal diagnosis
- (iv) Duplicate of principal diagnosis
- (v) Manifestation code as principal diagnosis
- (vi) Invalid age

(11) Consistency edits. The following edits will be applied to each patient data record to ensure the internal consistency of the patient data.

(A) The following edits from the Medicare Code Editor will be applied to the data. Data elements failing these edits will be rejected as errors.

- (i) Age conflict
- (ii) Sex conflict

(B) The following additional edits will be applied to the data. Data elements failing these edits will be rejected as errors.

(i) The sum of all charges for individual revenue codes must equal the total charges reported.

(ii) The total charges reported cannot be negative.

(iii) If a revenue code is reported, then charges must be reported for that revenue code.

(iv) If a revenue code between the values of 020 and 219 is reported, units of service must be reported for that revenue code.

(v) If a valid procedure code is reported, then a procedure day value which is less than or equal to the length of stay must be reported.

(vi) An operating practitioner must be reported for every principal procedure reported.

(vii) Birthweight must be coded if the Admission Status is newborn.

(Effective July 1, 1991)

Sec. 19a-167g-95—19a-167g-99. Reserved (Repealed)

Repealed June 11, 2014.

Notes: For 2014 repeal, see Sec. 54 of Public Act 14-187. (June 11, 2014)

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Agency

Department of Public Health

Subject

Statewide Trauma System

Inclusive Sections

§§ 19a-177-1—19a-177-9

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Sec. 19a-177-9.	Investigations and disciplinary action

Statewide Trauma System

Sec. 19a-177-1. Definitions

As used in section 19a-177-1 to 19a-177-9, inclusive, of the Regulations of Connecticut State Agencies:

- (1) “Department” means the Department of Public Health;
- (2) “EMS Advisory Board” means the advisory committee on emergency medical services established pursuant to section 19a-177(a) of the Connecticut General Statutes;
- (3) “Glasgow Coma Scale” or “GCS” means a standard and generally accepted scoring system for assessing a patient’s level of consciousness based on eye opening and response, verbal response, and motor response. The higher the total point score, the better the patient’s neurological status;
- (4) “Hospital” means an acute care hospital having facilities, medical staff and all necessary personnel to provide diagnosis, care, and treatment of a wide range of acute conditions, including injuries;
- (5) “Protocol” means a written instrument that guides the collection of data regarding the patient, provides for actions to be taken based on the collected data, and provides for a minimum level of safe practice in specific situations;
- (6) “Trauma” means a wound or injury to the body caused by accident, violence, shock, or pressure, excluding poisoning, drug overdose, smoke inhalation, and drowning;
- (7) “Traumatic brain injury” means damage to the brain tissue and any combination of focal and diffuse central nervous system dysfunction, both immediate or delayed, at the brain stem level and above. Such damage and dysfunctions are sustained through the application of external forces including, but not limited to, blows to the head, falls, vehicular crashes, assaults, sports accidents, intrauterine and birth injuries, and violent movement of the body. Such damage and dysfunctions are not developmental or degenerative, and not associated with aging;
- (8) “Trauma facility” means a hospital that has met the requirements as prescribed in section 19a-177-4 of the Regulations of Connecticut State Agencies and has received such designation from the Office of Emergency Medical Services (OEMS) in accordance with section 19a-177-3 of the Regulations of Connecticut State Agencies;
- (9) “Trauma registry” means a statewide data base to provide information to analyze and evaluate the quality of care of trauma patients and includes all admitted trauma patients, all trauma patients who died, all trauma patients who are transferred, and all traumatic brain injury patients.
- (10) “Trauma system” means an organized approach to providing care to trauma patients that provides personnel, facilities, and equipment for effective and coordinated trauma care. The trauma system: identifies facilities with specific capabilities to provide care, triages trauma victims at the scene, requires that all trauma victims be sent to an appropriate trauma facility, and collects and analyzes data for evaluation of the system. The trauma system includes prevention, prehospital care, hospital care, rehabilitation, data collection, and evaluation; and,

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(11) “Verification” means a review process carried out in accordance with section 19a-177-4 of the Regulations of Connecticut State Agencies.

(Adopted effective March 22, 1995; Amended September 6, 2005)

Sec. 19a-177-2. Administration

(a) The Office of Emergency Medical Services is the lead division within the department responsible for the development, implementation, evaluation and enforcement of the trauma system for the state of Connecticut.

(b) A Trauma Committee shall be established by the commissioner as a committee of the EMS Advisory Board.

(1) The committee shall include representatives from at least the following:

(A) Commission on Hospitals and Health Care (CHHC) or its successor agency(ies);

(B) Connecticut Committee on Trauma, American College of Surgeons, (CCT/ACS), four (4) persons, one of whom shall represent the interests of Level III, Level IV, or undesignated facilities;

(C) Connecticut College of Emergency Physicians (CCEP), four (4) persons, one of whom shall represent the interests of Level III, Level IV, or undesignated facilities;

(D) Connecticut Emergency Nurses Association (CENA);

(E) Connecticut Hospital Association (CHA);

(F) Paramedic Committee of the EMS Advisory Board; and

(G) Volunteer Committee of the EMS Advisory Board.

(2) The committee shall, at least annually:

(A) review protocols and recommend changes to the commissioner through the EMS Advisory Board; and

(B) evaluate the status of the trauma system and recommend changes to the commissioner through the EMS Advisory Board.

(Adopted effective March 22, 1995; Amended September 6, 2005)

Sec. 19a-177-3. Application by hospitals for trauma facility designation

(a) By October 1, 1995, all hospitals required to maintain an emergency service pursuant to Section 19-13-D3 of the Regulations of Connecticut State Agencies shall participate in the statewide trauma system as set forth in Sections 19a-177-1 through 19a-177-9 of the Regulations of Connecticut State Agencies by:

(1) giving triage medical direction in accordance with Section 19a-177-5 of the Regulations of Connecticut State Agencies;

(2) transferring patients in accordance with the requirements in Section 19a-177-6 of the Regulations of Connecticut State Agencies;

(3) participating in a quality assurance/improvement plan with the trauma registry in accordance with the requirements in Section 19a-177-6 of the Regulations of Connecticut State Agencies; and

(4) submitting data to the trauma registry in accordance with Section 19a-177-7 of the

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(b) Hospitals seeking designation as Level I, Level II, Level III, or Level IV trauma facilities shall apply to the OEMS for designation on forms supplied or approved by the OEMS.

(c) Within thirty (30) days of receipt of an application, the OEMS shall review the application for designation as a trauma facility for completeness and notify the hospital of the result of that review.

(1) If the application is deemed complete, the hospital shall be so notified in writing.

(2) If the application is deemed incomplete, the hospital shall be notified in writing of omissions or errors. The hospital may refile the application when complete, as a new application.

(d) Upon being notified by the OEMS of a complete application, the hospital shall, if not currently verified by the American College of Surgeons, Committee on Trauma, have ninety (90) days to initiate the verification process as outlined in Section 19a-177-4 of the Regulations of Connecticut State Agencies or the application shall be considered withdrawn. Should the verification report not be received by the OEMS within one hundred and eighty (180) days of such notification, an extension of not more than ninety (90) days may be granted by the OEMS upon the request in writing of the hospital. Only one (1) ninety (90) day extension shall be granted by the OEMS.

(e) The hospital shall forward to the OEMS a notarized copy of the verification report or notify the OEMS in writing of its wish to withdraw the application. The verification report shall be considered as an attachment to and part of the application of the hospital for designation as a trauma facility.

(f) Upon receipt of the verification report, the OEMS shall have ninety (90) days to consider the application of the hospital for designation as a trauma facility at the level requested. In addition to the verification report, the OEMS shall consider the facility's compliance with all other applicable DPHAS statutes and regulations.

(g) The OEMS shall notify the applicant hospital and the department in writing of its decision.

(h) Designation by the OEMS shall expire on the same date as the verification expiration date established by the American College of Surgeons in their verification report.

(i) Redesignation at the same level is contingent upon reverification by the American College of Surgeons, Committee on Trauma and reapplication to the OEMS. It is the hospital's responsibility to seek timely reverification.

(j) Once designated, a trauma facility may apply to the OEMS to surrender the designation at any time without giving cause by notifying the OEMS in writing with a plan for alternative patient care and giving a minimum of sixty (60) days notice. Surrender shall take effect only when approved by the OEMS. In such a case, the application and verification process shall be completed again before any designation may be reinstated.

(Adopted effective March 22, 1995; Amended September 6, 2005)

Sec. 19a-177-4. Verification process for trauma facility applicants

(a) To be designated as a trauma facility, a hospital shall meet the criteria contained in the American College of Surgeons' most recent version of the publication "Resources for Optimal Care of the Injured Patient" for the level of trauma facility for which it has applied. Verification from the American College of Surgeons, Committee on Trauma, is acceptable documentation that those criteria that are the same as the American College of Surgeons standard have been met. For those criteria that substantially differ, the department shall verify on its own that the applicant meets the criteria.

(b) Each hospital requesting designation as a trauma facility shall be responsible for all expenses of the verification process conducted by the American College of Surgeons.

(Adopted effective March 22, 1995; Amended September 6, 2005)

Sec. 19a-177-5. Field triage protocols

(a) The following field triage protocol shall provide criteria to categorize trauma patients and determine destination hospitals with resources appropriate to meet the patient's needs.

1. Assess the physiologic signs. Trauma patients with any of the following physiologic signs shall be taken to a Level I or Level II trauma facility:

- (A) Glasgow Coma Scale of twelve (12) or less; or
- (B) systolic blood pressure of less than ninety (90) mm Hg; or
- (C) respiratory rate of less than ten (10) or more than twenty-nine (29) breaths per minute.

2. Assess the anatomy of the injury. Trauma patients with any of the following injuries shall be taken to a Level I or Level II trauma facility:

- (A) gunshot wound to chest, head, neck, abdomen or groin;
- (B) third degree burns covering more than fifteen (15) per cent of the body, or third degree burns of face, or airway involvement;
- (C) evidence of spinal cord injury;
- (D) amputation, other than digits; or
- (E) two (2) or more obvious proximal long bone fractures.

3. Assess the mechanism of injury and other factors and, if any of the following is present, determination of destination hospital shall be in accordance with medical direction:

- (A) Mechanisms of injury:
 - (1) falls from over twenty (20) feet;
 - (2) apparent high speed impact;
 - (3) ejection of patient from vehicle;
 - (4) death of same car occupant;
 - (5) pedestrian hit by car going faster than twenty (20) MPH;
 - (6) rollover; or
 - (7) significant vehicle deformity – especially steering wheel.
- (B) Other factors
 - (1) age less than five (5) or greater than fifty-five years;
 - (2) known cardiac or respiratory disease;

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(3) penetrating injury to thorax, abdomen, neck, or groin other than gunshot wounds.

4. Severely injured patients less than thirteen (13) years of age should be taken to a Level I or II facility with pediatric resources including a pediatric ICU.

5. When transport to a Level I or II trauma facility is indicated but the ground transport time to that hospital is judged to be greater than twenty (20) minutes, determination of destination hospital shall be in accordance with local medical direction.

6. If, despite therapy, the trauma patient's carotid or femoral pulses can not be palpated, airway can not be managed, or external bleeding is uncontrollable, determination of destination hospital shall be in accordance with local medical direction.

7. When in doubt regarding determination of destination hospital, contact medical direction.

(b) All EMS providers transporting trauma patients to hospitals shall provide receiving hospitals with a completed OEMS approved patient care form prior to departing from the hospital. A patient care form shall be completed for each trauma patient at the scene who is not transported and shall be forwarded to the OEMS.

(c) Beginning October 1, 1995, all hospitals and EMS providers shall follow the field triage protocols.

(Adopted effective March 22, 1995)

Sec. 19a-177-6. Interhospital transfers

(a) If a trauma patient who meets the Field Triage Protocol criteria for delivery to a Level I or Level II trauma facility is taken to a facility not so designated, that patient shall be transferred to a Level I or Level II trauma facility or the reason that the trauma patient is admitted, discharged or transferred to a different facility shall be documented in the patient's hospital record.

(b) For all interhospital transfers the sending hospital shall:

- (1) document patient assessment and efforts to stabilize;
- (2) communicate with medical and nursing staff at the receiving hospital;
- (3) provide medically appropriate staff and orders for transporting personnel;
- (4) transfer copies of the entire chart with copies of any x-rays and laboratory data; and
- (5) document, by name, all parties contacted in arranging the transfer.

(c) Level I or Level II trauma facilities shall not refuse the transfer of trauma patients who fall within their designated level of capability unless their ability to provide that level of care is compromised.

(d) The Trauma Committee shall use the following peer review quality assurance/improvement plan to review interhospital transfers:

(1) The care and treatment of trauma patients is to be carried out by each hospital in accordance with standards established by the hospital, its medical staff, and these regulations.

(2) Data collected in accordance with section 19a-177-7 of the Regulations of Connecticut State Agencies shall be supplied to the hospital's internal quality review process

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and the trauma registry.

(3) The trauma registry shall review and evaluate the data it receives from the hospital for completeness and accuracy.

(4) If data are incomplete or inaccurate the trauma registry shall notify the hospital that the data must be adjusted and re-submitted.

(5) The trauma registry shall produce summaries and reports and forward them to the trauma committee.

(6) Summaries and reports provided by the trauma registry shall be reviewed by the trauma committee to determine if the trauma system standards are being met, including the identification of significant deviations from norms, and to determine if further research is needed to improve the trauma system standards.

(7) The trauma committee shall report back to the hospital and when it believes trauma system standards are not being met may suggest changes that will assist the hospital in meeting those standards.

(8) Should the trauma committee determine that a hospital continues to fail to meet trauma system standards, the trauma committee may make recommendations for action to the Commissioner through the EMS Advisory Board.

(9) Beginning October 1, 1995, all hospitals shall follow the interfacility transfer protocols.

(e) Data and reports used in the peer review quality assurance/improvement plan shall be kept confidential pursuant to sections 19a-25 and 1-19 of the Connecticut General Statutes.

(Adopted effective March 22, 1995)

Sec. 19a-177-7. Data collection

(a) Trauma registry

(1) The trauma registry shall include data:

(A) on all admitted trauma patients and all traumatic brain injury patients;

(B) on all trauma patients who died in the field, in the Emergency Department and in the hospital; and,

(C) on all trauma patients and all traumatic brain injury patients who are transferred.

(2) Beginning October 1, 1995, for all nonscheduled transports of trauma patients and all traumatic brain injury patients each emergency medical service provider shall provide, on forms approved by the commissioner, to the receiving hospital prior to departing from the hospital, the following data. The forms shall become a part of the patient's medical record at the receiving hospital, and shall include but not necessarily be limited to:

(A) ambulance service identification number;

(B) ambulance run number;

(C) patient's name;

(D) patient's gender and ethnicity;

(E) patient's date of birth;

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- (F) injury date and time of onset of injury or medical problem;
- (G) town and zip code location of site of EMS response;
- (H) time of dispatch of first responder;
- (I) time of arrival of first responder at scene of the injury/incident;
- (J) time of dispatch of ambulance;
- (K) time of arrival of ambulance at scene of the injury/incident;
- (L) time of departure from scene of the injury/incident;
- (M) time of arrival at hospital;
- (N) transport interventions;
- (O) Glasgow eye opening at scene of the injury/incident;
- (P) Glasgow verbal at scene of the injury/incident;
- (Q) Glasgow motor response at scene of the injury/incident;
- (R) systolic blood pressure at scene of the injury/incident;
- (S) respiratory rate at scene of the injury/incident;
- (T) date of transport;
- (U) work related injury/medical problem;
- (V) extrication time if motor vehicle accident;
- (W) place where injury occurred;
- (X) type and use of protective equipment; and
- (Y) mechanism of injury.

(3) Beginning October 1, 1995, each licensed Connecticut acute care hospital shall provide, on forms approved by the commissioner, to the trauma registry the following data:

(A) for all trauma patients and all traumatic brain injury patients admitted to the hospital, transferred to another hospital, or discharged dead:

- (1) data elements defined in subdivision (2) of this subsection;
- (2) patient's health insurance identification number;
- (3) patient's zip code of residence;
- (4) emergency department admission and discharge Glasgow eye opening;
- (5) emergency department admission and discharge Glasgow verbal response;
- (6) emergency department admission and discharge Glasgow motor response;
- (7) emergency department admission and discharge systolic blood pressure;
- (8) emergency department admission and discharge respiratory rate;
- (9) patient's social security number;
- (10) referring hospital identification number;
- (11) emergency department record number (if different than inpatient record number);
- (12) mode of arrival at the emergency department;
- (13) trauma team alerted, yes or no;
- (14) times of notification and arrival of neurosurgeon;
- (15) times of notification and arrival of trauma surgeon;
- (16) emergency department interventions;
- (17) date and time of discharge from emergency department;

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- (18) disposition from emergency department;
- (19) receiving facility post discharge;
- (20) documentation of hourly Glasgow coma score and vital signs; and
- (21) medical examiner's case number.
- (B) for all trauma patients and all traumatic brain injury patients admitted as inpatients:
 - (1) inpatient medical record number;
 - (2) first head CT scan date and time;
 - (3) first neurosurgery date and time,
 - (4) first orthopedic surgery date and time;
 - (5) first thoracic/abdominal surgery date and time;
 - (6) unanticipated return to the operating room within forty-eight (48) hours;
 - (7) discharge expression;
 - (8) discharge locomotion;
 - (9) discharge self feeding;
 - (10) medical examiner's case number;
 - (11) E-codes;
 - (12) hospital identification code;
 - (13) anatomic diagnoses;
 - (14) diagnoses onset;
 - (15) ICD codes for traumatic brain injury patients;
 - (16) charges by cost center;
 - (17) attending physician;
 - (18) operating physician;
 - (19) principle diagnosis as defined by ICD-9-CM codes;
 - (20) secondary diagnoses as defined by ICD-9-CM codes;
 - (21) principle procedure as defined by ICD-9-CM codes and date;
 - (22) secondary procedures as defined ICD-9-CM codes and dates of procedures;
 - (23) inpatient disposition;
 - (24) expected principle source of payment;
 - (25) psychiatric or rehabilitation unit discharge;
 - (26) race;
 - (27) discharge time;
 - (28) discharge date;
 - (29) total charges;
 - (30) admission date;
 - (31) admission time;
 - (32) days in ICU;
 - (33) days in CCU; and
 - (34) payor source.

(4) Beginning October 1, 1995, for all trauma patients and all traumatic brain injury patients who are immediate transfers from an acute care facility to a rehabilitation service,

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each provider of rehabilitation services shall provide, on forms approved by the commissioner, to the trauma registry the following data:

- (A) admission date;
- (B) referring facility;
- (C) patient's date of birth;
- (D) patient's gender;
- (E) patient's zip code;
- (F) total charges;
- (G) functional independence measures on admission and discharge,
 - (i) eating,
 - (ii) grooming,
 - (iii) bathing,
 - (iv) dressing,
 - (v) toileting,
 - (vi) bladder management,
 - (vii) mobility,
 - (viii) locomotion,
 - (ix) communication,
 - (x) social cognition, and
 - (xi) total function independence measure;
- (H) patient's health insurance claim number and social security number;
- (I) discharge date;
- (J) disposition from rehabilitation;
- (K) discharge expression;
- (L) discharge locomotion;
- (M) discharge self feeding; and
- (N) hospital identification code.

(5) Beginning October 1, 1995, for all deaths that occur as a result of injury outside a hospital, the trauma registry shall obtain from the state medical examiner the data specified in this subsection:

- (A) date of injury/incident;
- (B) time of injury/incident;
- (C) location of injury/incident;
- (D) type of injury/incident;
- (E) victim's date of birth;
- (F) victim's gender;
- (G) name of pre-hospital provider service, if applicable;
- (H) results of the autopsy, if performed;
- (I) cause of death;
- (J) death date;
- (K) place of death;

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- (L) victim's race;
 - (M) victim's residence address;
 - (N) victim's residence zip code; and
 - (O) victim's social security number.
- (6) All data required by subdivisions (2), (3), (4), and (5) of this subsection shall be submitted by the following schedule:
- (A) first quarter due June 30;
 - (B) second quarter due September 30;
 - (C) third quarter due December 30; and
 - (D) fourth quarter due March 30.
- (7) The trauma registry shall maintain, process, and analyze such data as are needed to provide to the commissioner the following summary data reports within ninety (90) days after the data are due for each quarter:
- (A) EMS provider response time by region;
 - (B) EMS provider response time for Connecticut;
 - (C) mechanism of injury by region;
 - (D) type of injury by region;
 - (E) type of injury, severity and categorization level of triage hospital (Level I, II, III, and IV as designated by the OEMS);
 - (F) safety device use frequency by type of device;
 - (G) type, severity, and mechanism of injury by town of injury occurrence;
 - (H) number of deaths taken directly to the morgue; and
 - (I) other special studies at an aggregate level at the request of the commissioner that shall facilitate the department's ability to follow a patient through the statewide trauma system.
- (b) If the patient is further transported from one acute care hospital to another acute care hospital, a copy of the completed patient care form shall be provided by the sending hospital to the emergency medical service transport personnel and provided to the receiving hospital.
- (c) The information contained in the trauma registry shall be made available only to those who have been approved for use of the information by the commissioner pursuant to section 19a-6e of the Connecticut General Statutes and in accordance with sections 19a-25-1 through 19a-25-4, inclusive, of the Regulations of Connecticut State Agencies.
- (d) Summary data will be available for public inspection and distribution. However, data containing patient specific information and provider and facility identification shall not be available and shall be kept confidential pursuant to sections 19a-25, 19a-6e and 1-210 of the Connecticut General Statutes.
- (e) Each emergency medical service provider shall supply an annual report to the commissioner on all transports. Annual reports for the year ending June 30 shall be due by September 30 each year. Reports shall include:
- (1) number of transports per emergency medical service provider;
 - (2) number of prior arranged transports;

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- (3) number of transports not arranged prior to the call that results in dispatch;
- (4) number of paramedic intercepts; and
- (5) number of helicopter assists.

(f) Ownership of data. All raw data collected and maintained by the department or pursuant to a contract with the commissioner shall remain the property of the department. All raw data collected and maintained by a contractor independent of a contract with the commissioner shall remain the property of the contractor.

(Adopted effective March 22, 1995; Amended September 6, 2005)

Sec. 19a-177-8. Prohibited acts

(a) No facility, institution or other entity shall represent itself to be a trauma facility unless it is designated as such by the OEMS.

(b) No designated trauma facility shall advertise services or capabilities for the treatment of trauma patients above those for which it has been designated.

(c) No EMS provider shall take a trauma patient meeting the criteria as determined by the field triage protocols to a hospital other than the facility identified by either protocol or medical direction.

(Adopted effective March 22, 1995)

Sec. 19a-177-9. Investigations and disciplinary action

(a) The department may investigate any reported failure to comply with sections 19a-177-1 to 19a-177-9, inclusive, of the Regulations of Connecticut State Agencies. Failure to cooperate in providing documentation and interviews with appropriate department staff shall constitute grounds for disciplinary action.

(b) Based on findings in subsection (a) of this section, the commissioner may require a hospital to become reverified by the American College of Surgeons as a basis for continued designation as a trauma facility. The expenses of such reverification review shall be borne by the hospital.

(Adopted effective March 22, 1995; Amended September 6, 2005)

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Subject

Equipment Grants for Emergency Medical Services

Inclusive Sections

§§ 19a-178b-1—19a-178b-6

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Equipment Grants for Emergency Medical Services

Sec. 19a-178b-1. Definitions

As used in section 19a-178b-1 to section 19a-178b-6, inclusive, of the Regulations of Connecticut State Agencies:

- (1) “Commissioner” means the Commissioner of Public Health;
- (2) “Department” means the department of public health;
- (3) “Equipment” means a nondisposable, reusable item used by emergency medical services personnel in providing direct patient care. Emergency medical services personnel includes Medical Response Technicians, Emergency Medical Technicians, Emergency Medical Technicians-Intermediate, and Paramedics;
- (4) “Grant” means an award of money made by the commissioner in accordance with section 19a-178b of the Connecticut General Statutes, and sections 19a-178b-1 through 19a-178b-6, inclusive, of the Regulations of Connecticut State Agencies;
- (5) “Grant cycle” means the twelve month period beginning on the first day of July following approval of a grant application and ending on the thirtieth day of June of the following year, unless otherwise provided in sections 19a-178b-1 through 19a-178b-6, inclusive, of the Regulations of Connecticut State Agencies, or approved by the commissioner;
- (6) “Grantee” means the emergency medical services organization to which a grant is awarded in accordance with sections 19a-178b-1 through 19a-178b-6, inclusive, of the Regulations of Connecticut State Agencies. Emergency medical services organizations include licensed or certified First Responders, Basic Ambulance Services and Mobile Intensive Care Services which operate on a non-profit basis or are municipal entities;
- (7) “Justification of need” means a written explanation submitted as part of a grant application; and,
- (8) “Training equipment” means a nondisposable, reusable item used for the training of patient care skills in a program accredited or approved under sections 19a-178b-1 through 19a-178b-6, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective August 15, 2000)

Sec. 19a-178b-2. General provisions

(a) The commissioner may award grants subject to the availability of funds for the program established pursuant to section 19a-178b of the Connecticut General Statutes and sections 19a-178b-1 through 19a-178b-6, inclusive, of the Regulations of Connecticut State Agencies.

(b) Grant proposals shall be solicited by the commissioner through such means of public notice as he deems appropriate, including, but not limited to major newspapers, trade publications, emergency medical services organizations, and industry newsletters.

(c) The commissioner shall, with the advice of the Connecticut Emergency Medical Services Advisory Board, establish a list of priorities in the types of grant projects eligible for funding.

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(d) The commissioner, with review and comment of the regional emergency medical services councils, has sole discretion in approving or denying any, all, or a portion of a grant application.

(e) Grant funds shall be used solely to improve and expand prehospital emergency medical services in Connecticut.

(Adopted effective August 15, 2000)

Sec. 19a-178b-3. Criteria for eligibility

(a) The commissioner shall only approve grants for applicants who are eligible to be grantees pursuant to section 19a-178b of the Connecticut General Statutes, and sections 19a-178b-1 through 19a-178b-6, inclusive, of the Regulations of Connecticut State Agencies.

(b) All emergency medical service providers licensed or certified by the department under section 19a-180 of the Connecticut General Statutes shall be eligible to apply for and receive grants under section 19a-178b of the Connecticut General Statutes, and sections 19a-178b-1 through 19a-178b-6, inclusive, of the Regulations of Connecticut State Agencies, if they operate on a nonprofit basis exclusively for the benefit of the general public or are municipal entities.

(c) In reviewing applications for grants, priority shall be given to those applicants which have underdeveloped or aged emergency medical equipment or systems.

(d) Grant funds shall not be used to replace, decrease or reallocate the existing, budgeted moneys of or provided to the emergency medical services provider by local governmental bodies.

(e) An eligible grantee shall comply with all applicable provisions of sections 19a-178b-1 through 19a-178b-6, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective August 15, 2000)

Sec. 19a-178b-4. Grant applications

(a) Grant applications shall be submitted on forms approved by the department.

(b) All grant applications shall bear the original signature of the chief executive officer of the applicant.

(c) A grant application shall be submitted on forms prescribed by the Office of Emergency Medical Services which shall include, at a minimum, the following documents and information:

(1) federal tax identification number of the applicant;

(2) contact person, address, and telephone number for the applicant;

(3) category of grant to which application relates;

(4) justification of need including:

(A) the demonstrated need within the community;

(B) the degree to which the proposal serves the state and regional emergency medical services system plan;

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(C) the extent to which there is available adequate trained staff to carry out the proposal; and

(D) the population affected using the most recent population estimates by the department;

(5) grant agreement form prescribed by the Office of Emergency Medical Services containing the applicant's agreement to comply with and be bound by all of the grant restrictions and requirements of sections 19a-178b-1 through 19a-178b-6, inclusive, of the Regulations of Connecticut State Agencies;

(6) authorized signature of the chief executive officer of the applicant;

(7) submission date of completed application;

(8) approval of the chief elected official of the town or towns whose population is most directly affected by the grant; and

(9) a proposed work plan for utilization of grant funds.

(d) Except as otherwise provided in sections 19a-178b-1 through 19a-178b-6, inclusive, of the Regulations of Connecticut State Agencies, or approved by the commissioner, all grant applications shall:

(1) be received by, or postmarked not later than, five p.m. of the second day of January in order to be considered for a grant cycle commencing on the first day of July of the same year; or

(2) be received by, or postmarked not later than five p.m. of the next regular business day, for calendar years in which the second day of January is a Saturday or Sunday.

(e) Applications shall be submitted to the department, Office of Emergency Medical Services, at such address as is specified in the application form.

(f) The Office of Emergency Medical Services shall provide written verification to each applicant not later than thirty working days after receipt of an application package that satisfies the requirements of sections 19a-178b-1 through 19a-178b-6, inclusive, of the Regulations of Connecticut State Agencies and shall within thirty working days forward a complete copy of the grant application to the applicable regional council or councils for their review and comment. The written comment of the applicable regional councils shall be received in the Office of Emergency Medical Services not later than forty-five days after the council's receipt of said application.

(g) Notwithstanding the provisions of this section and sections 19a-178b-1 and 19a-178b-2 of the Regulations of Connecticut State Agencies, for the first round of grant awards to be distributed by the commissioner following the effective date of sections 19a-178b-1 through 19a-178b-6, inclusive, of the Regulations of Connecticut State Agencies, the commissioner shall establish an appropriate application deadline date and grant cycle and shall make a good faith effort to inform all potential grant applicants of the availability of grant funds, the application deadline, the dates of the grant cycle, and any other information he considers relevant.

(Adopted effective August 15, 2000)

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Sec. 19a-178b-5. Grant restrictions and requirements

(a) Grant funds shall not be used for activities or purchases related to an approved grant project if such activities were commenced, or such purchases were made or obligated, prior to formal approval of the grant application by the commissioner.

(b) The commissioner shall have the discretion to restrict the type of expenses for which grant funds may be used. Unless otherwise authorized in writing by the commissioner, expenses for which grant funds shall not be used include the following:

- (1) grant preparation or administration;
- (2) salaries;
- (3) meals or lodging;
- (4) travel expenses;
- (5) equipment to be used exclusively by one individual;
- (6) capital project expenditures including the purchase or construction of buildings or structures;
- (7) purchase or lease of real property or vehicles;
- (8) operation expenses not related to the improvement or expansion of prehospital emergency medical services in Connecticut.

(c) Grants awarded for emergency medical services training shall be used only for tuition and fees, books, materials, and other expenses related directly to participation in the training program.

(d) Grant funds shall only be expended by the grantee to which the grant is awarded. Failure to comply with this requirement shall be considered to be misappropriation of funds and shall result in forfeiture of unexpended grant funds. The grantee shall be obligated to repay any funds determined by the commissioner to have been inappropriately expended.

(e) A grantee who expends grant funds for purposes other than those authorized under sections 19a-178b-1 through 19a-178b-6, inclusive, of the Regulations of Connecticut State Agencies and approved by the commissioner shall be subject to forfeiture of unexpended funds, repayment of any grant funds determined by the commissioner to have been used for an unauthorized purpose, and at the commissioner's discretion, considered ineligible for funding in future grant cycles.

(f) Within seven days after requested by the commissioner or his designee, a grantee shall supply original or verifiable copies of all receipts and other appropriate documentation related to disposition of the grant funds.

(g) Except as otherwise provided in sections 19a-178b-1 through 19a-178b-6, inclusive, of the Regulations of Connecticut State Agencies, all grant funds must be expended or obligated by a grantee within the twelve month grant cycle for which they were awarded.

(h) Any grant funds not expended or obligated on the final day of the grant cycle shall be remitted to the department not later than thirty days following the end of the grant cycle.

(1) A grantee who fails to expend the full amount of a grant shall not be adversely impacted in future grant cycles provided that all unexpended grant funds are remitted to the department.

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(2) A grantee who fails to remit unexpended grant funds as provided in sections 19a-178b-1 through 19a-178b-6, inclusive, of the Regulations of Connecticut State Agencies shall be considered ineligible for funding in future grant cycles until such time as unexpended funds are remitted to the department.

(i) A final report accounting for all grant funds expended by a grantee shall be submitted to the commissioner or his designee not later than thirty days after the end of the grant cycle.

(j) All expenditures and disbursements of grant funds by a grantee shall be subject to generally accepted accounting principles.

(Adopted effective August 15, 2000)

Sec. 19a-178b-6. Categories of grants

(a) Subject to the general provisions of sections 19a-178b-1 through 19a-178b-6, inclusive, of the Regulations of Connecticut State Agencies, and to the availability of funds, the commissioner may review and award grants in any or all of the following categories:

- (1) personnel training;
- (2) training equipment;
- (3) patient care equipment;
- (4) research projects;
- (5) local system development projects; and
- (6) any other category that the commissioner determines is consistent with the terms of section 19a-178b of the Connecticut General Statutes.

(b) Equipment may be purchased with grant funds provided that the purchase satisfies all of the following:

- (1) The equipment is not intended for use, nor will be used, exclusively by one individual;
- (2) The grantee provides assurances that the equipment will be retained by the grantee and used in accordance with the terms of the grant award for the useful life of the equipment;
- (3) Grant funds represent not more than seventy per cent (70%) of the total purchase or acquisition price;

(4) The grantee provides, or secures from other funding sources, the balance of funding for the purchase or acquisition of equipment;

(c) Unless otherwise expressly waived by the commissioner, grants awarded for research projects are subject to all of the following:

- (1) Grant funds may not be used to purchase or acquire equipment for use in research projects, however, grant funds may be used to defray the costs of renting or leasing equipment involved in a research project;
- (2) Grantee shall comply with all state and federal statutes and regulations applicable to the project;
- (3) All data and information resulting from such research projects shall be available for use by the State of Connecticut, Department of Public Health; and
- (4) Grantee shall submit to the commissioner a final report on any findings and

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conclusions of the research project not later than one hundred and twenty days after completion of the project.

(d) In a given grant cycle, the commissioner shall award not more than ten per cent (10%) of available grant funds, as determined in accordance with sections 19a-178b-1 through 19a-178b-6, inclusive, of the Regulations of Connecticut State Agencies, to applicants for research project grants.

(Adopted effective August 15, 2000)

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Sec. 19a-179-1. Emergency medical services regulations. Definitions

Those definitions set forth in C.G.S. Sec. 19a-175 shall govern the provisions of these regulations, in addition to the following:

(a) “Activation time” means the measure of time from notification to the EMS provider that an emergency exists, to the beginning of the response of the emergency vehicle.

(b) “Advertising” means the promotion or announcement of one’s business name and services in a manner intended to attract members of the public to use such business services.

(c) “Commissioner” means the commissioner of health services as defined in Sec. 19a-175 of the C.G.S.

(d) “Council” means regional emergency medical services council.

(e) “Director” means the director of the office of emergency medical services (OEMS).

(f) “Dispatch Center” means the organization responsible for receiving emergency calls and notifying the appropriate emergency medical service providers of such calls for help, and assigning them to respond to such calls.

(g) “Emergency Medical Services Provider” or “EMS Provider” means a person, association, or organization who provides immediate and/or life saving transportation and medical care away from a hospital to a victim of sudden illness or injury, and who may also provide invalid coach services.

(h) “Emergency Medical Services Instructor” or “EMS-I” means an individual who has successfully completed the requirements of Sec. 19a-179-16 (d) of these regulations and is certified by the office of emergency medical services to teach, supervise and conduct courses in EMS training programs.

(i) “Emergency Medical Technician” or “EMT” means an individual who has successfully completed the requirements established by Sec. 19a-179-16 (b) of these regulations and is certified as an EMT by the office of emergency medical services.

(j) “Emergency Medical Technician–Intermediate” or “EMT-I” means an individual who has successfully completed the requirements established by Sec. 19a-179-16 (c) of these regulations and is certified as an EMT-I by the office of emergency medical services.

(k) “Emergency Medical Technician–Paramedic” or “EMT-P” means an individual who has successfully completed the requirements established by Sec. 19a-179-16 (c) of these regulations and is certified as an EMT-P by the office of emergency medical services.

(l) “First Responder” means the EMS provider who is notified for initial response to a victim of sudden illness or injury.

(m) “Invalid Coach Transportation” means transportation to or from a private home, health care facility, or hospital for examination, diagnosis, treatment, therapy or consultation. Invalid Coach transportation is only to include the transportation of non-stretcher patients for whom the need for resuscitation, suctioning, or other emergency medical care or continuous observation is not evident.

(n) “Medical Communications Coordination Center” means an organization responsible for the coordination of medical frequencies to ensure allocation of such frequencies on a

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priority basis to EMS personnel requesting communications with a medical facility.

(o) “Medical Control” means the active surveillance by physicians of mobile intensive care sufficient for the assessment of overall practice levels as defined by statewide protocols.

(p) “Medical Direction” means the provision of medical advice, consultation, instruction and authorization to appropriately trained or certified personnel by designated staff members at sponsor hospitals.

(q) “Medical Response Technician” or “MRT” means an individual who has successfully completed the requirements established by Sec. 19a-179-16 (a) of these regulations and is certified as an MRT by the office of emergency medical services.

(r) “Mobile Intensive Care” or “MIC” means pre-hospital care involving invasive or definitive skills, equipment, procedures, and other therapies.

(s) “Mobile Intensive Care Medical Director” means a physician on the staff of the sponsor hospital, appointed by the sponsor hospital to be medically responsible for the facility’s participation in the mobile intensive care system.

(t) “Mobile Intensive Care Service” means the organized provision of intensive, complex prehospital care, consistent with acceptable emergency medical practices, utilizing qualified personnel supervised by physicians and hospitals as part of a written emergency medical services agreement with the mobile intensive care provider.

(u) “Mobile Intensive Care Unit” means an emergency vehicle equipped in accordance with Sec. 19a-179-18 (b) of these regulations and operated by a mobile intensive care provider.

(v) “Mutual Aid” means a written agreement between emergency medical service providers or among a group of such providers to ensure cooperative aid in times of need.

(w) “Office of Emergency Medical Services” or “OEMS” means the office established within the department of health services pursuant to C.G.S. Sec. 19a-178.

(x) “Primary Service Area Responder” or “PSAR” means the designated EMS provider for first call in a primary service area.

(y) “Primary Service Area” or “PSA” means a specific municipality or part thereof, to which one designated EMS provider is assigned for each category of emergency medical response services.

(z) “Regional Medical Advisory Committee” or “RMAC” means a committee composed of physicians and other members appointed by the regional emergency medical services council, for the purpose of advising the council on medical practices and medical quality assurances.

(aa) “Regional Medical Director” means a physician licensed to practice medicine in Connecticut who is authorized by the council to develop and represent council positions on medical matters.

(bb) “Response Time” means the total measure of time from notification to the EMS provider that an emergency exists, to arrival of the EMS provider at the patient’s side, and is the total of “activation time” and “travel time.”

(cc) “Sponsor Hospital” means a hospital which has agreed to maintain staff for the

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provision of medical control to emergency medical service providers and which has been approved by OEMS in accordance with Sec. 19a-179-12 (a) (7) of these regulations.

(dd) “State Medical Advisory Committee” or “SMAC” means a committee composed of the medical directors of each regional emergency medical services council and the medical director of OEMS, for the purpose of advising the OEMS on medical matters within the emergency medical services system in the state.

(ee) “Travel Time” means the measure of time from the beginning of the response of the emergency vehicle to arrival on scene.

(Effective July 2, 1993)

Sec. 19a-179-2. Regional emergency medical services councils

(a) There shall be a regional emergency medical services council in each EMS region of the state, such regional council boundaries shall be designated by the commissioner. Each council shall provide advice and guidance on policy to OEMS and the regional coordinator as to the regional problems, needs, and priorities in the area of emergency medical services.

(b) Opportunity for membership on each council shall be available to all appropriate representatives of emergency medical services including, but not limited to, one representative from each of the following:

- (1) Local governments;
- (2) Fire service and law enforcement officials;
- (3) Medical and nursing professions, including mental health, paraprofessional and other allied health professions;
- (4) Providers of ambulance services, certified and licensed;
- (5) Institutions of higher education;
- (6) Consumers

(c) Each regional emergency medical services council shall consider matters of policy and priority regarding emergency medical services within its region and shall annually develop an EMS plan for its region and submit the plan annually to OEMS.

(d) The Council shall submit to OEMS for its approval information concerning its organizational structure, membership, officers and by-laws pursuant to C.G.S. Sec. 19a-183. Any changes in this submitted information shall be forwarded to OEMS quarterly.

(e) Each regional council shall review and within sixty (60) days forward to the commissioner, together with its recommendations, all grant and contract applications for federal and state funding pertaining to emergency medical services.

(Effective June 14, 1988)

Sec. 19a-179-3. Regional EMS coordinators

(a) There shall be a regional EMS coordinator in each region who shall be appointed by the regional EMS council, subject to the Commissioner’s approval that the EMS coordinator can perform the duties in this section in a manner as to enhance the EMS system. In those regions where no regional EMS council exists, such coordinator shall be appointed by the

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commissioner.

(b) The regional EMS coordinator shall be responsible for the following:

(1) Facilitating the work of the regional EMS council in developing the plan for the coordination of emergency medical services within the region;

(2) Implementing the regional EMS plan;

(3) Continuous monitoring and evaluation of all emergency medical services in that region;

(4) Making a complete inventory of all personnel, facilities and equipment within the region related to the delivery of emergency medical services pursuant to guidelines established by the commissioner.

(5) Maintaining liaison with the director of OEMS or his or her designee;

(6) Acting as staff for the council;

(7) Coordinating EMS planning activities related to disasters and mass casualty events and assisting in the establishment of mutual aid agreements; and,

(8) Performing such other duties as are negotiable between the council and the commissioner.

(Effective June 14, 1988)

Sec. 19a-179-4. Primary service area responder (PSAR)

(a) OEMS shall assign, in writing, a primary service area responder for each primary service area. All municipalities within the State of Connecticut shall be covered by said assignments. Primary service area responders shall be either licensed or certified by OEMS pursuant to C.G.S. Sec. 19a-180. An express condition of licensure or certification as an emergency medical service provider shall be the availability and willingness of the emergency medical service provider to properly carry out any PSAR assignment made by OEMS pursuant to this section of these regulations.

(b) The factors to be considered by OEMS in assigning any emergency medical services provider as a PSAR shall be as follows:

(1) Size of population to be served;

(2) Effect of proposed PSAR assignment on other emergency medical service providers in the area;

(3) Geographic locations of the proposed PSAR provider;

(4) The proposed PSAR's record of response time;

(5) The proposed PSAR's record of activation time;

(6) The proposed PSAR's level of licensure or certification; and,

(7) Other factors which OEMS determines to be relevant to the provision of efficient and effective emergency medical services to the population to be served.

Prior to such assignment, OEMS shall solicit the advice and recommendation of the appropriate regional council and the chief administrative official of the municipality in which the PSAR lies for consideration in light of the above factors.

(c) Each PSAR shall be assigned to only one designated response service for each given

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category of service available. Any circumstances under which another designated response service would receive first call priority, such as central dispatch sending the closest available vehicle, shall be stipulated in the assignment of the PSAR.

(d) A PSAR assignment may be withdrawn when it is determined by OEMS that it is in the best interests of patient care to do so. Upon transmittal to OEMS of the recommendation of the appropriate regional council, along with reasons in support of said recommendation, that withdrawal of a PSAR assignment is appropriate, OEMS shall institute proceedings pursuant to C.G.S. Sec. 19a-177 through Sec. 19a-182, inclusive, and the applicable regulations of the department of health services promulgated thereunder. The regional council and the designated primary service area responder shall be permitted to present evidence and arguments to the commissioner in support of their respective positions. Upon consideration of the council recommendation and any other evidence or argument presented, the commissioner shall make a decision, in writing, whether to withdraw the assignment. If an assignment is withdrawn, OEMS shall at the same time assign the PSAR responsibility to another provider. The commissioner may initiate such proceedings without being requested to do so by the council, but shall notify the council of its intent.

(e) Where the chief administrative official of the municipality in which the PSA lies can demonstrate to the commissioner that an emergency exists and that the safety, health and welfare of the citizens of the affected area are jeopardized by the performance of the assigned primary service area responder, that chief administrative official may petition the commissioner, in writing, to suspend the assignment immediately. In such cases, the chief administrative official shall develop a plan acceptable to the commissioner for the alternative provision of primary service area responder responsibilities. Upon a finding that an emergency exists and that the safety, health, and welfare of the citizens of the affected area are jeopardized by the performance of the assigned primary service area responder, the commissioner may suspend the assignment immediately and order a plan for alternative provision of emergency medical services, pending prompt compliance with the requirements of the subsection (d) above.

(Effective June 14, 1988)

Sec. 19a-179-5. Licensure and certification

(a) Any person wishing to provide emergency medical services shall apply to the OEMS for a license or a certificate as appropriate to the service offered in accordance with C.G.S. Sec. 19a-180 and any regulations promulgated thereunder. All response services shall apply to the OEMS indicating that such service is a duly incorporated agency under Connecticut law, with a chief executive officer who shall sign the application for certification or licensure and who is specifically accountable for the EMS operations as such agency, or that such service is a duly designated element of a governmental body with a chief executive officer who shall sign the application for certification or licensure and with an officer of the agency who shall be directly responsible for EMS operations of that agency. Such application shall be made on forms provided by the OEMS and shall contain sufficient information to

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establish that the proposed service complies with all limitations, conditions and procedures required by the OEMS in accordance with C.G.S. Sec. 19a-175 through Sec. 19a-179, inclusive, Regulations of Connecticut State Agencies, Sec. 19a-180-1 to 19a-180-10, inclusive and these regulations.

(b) Each service holding a license shall apply on forms provided by the OEMS for renewal of such license not later than December 31st of each calendar year. Each service holding a certificate of operation shall apply on forms provided by the OEMS for renewal of such certificate not later than the last day of each assigned quarter during the calendar year. Applications for annual licensure or certification renewal shall include the following information:

- (1) Services to be provided;
- (2) Address of business location;
- (3) Total number of EMS vehicles, by category;
- (4) Certificates of malpractice and public liability insurance;
- (5) Name and address of any owner of the service in the case of a commercial service, and the names and addresses of its officers if the owner is a corporation, or the name and address of officers in the case of a volunteer service, or the name and address of the chief elected official and any other municipal service;
- (6) Agent for service of process and all other official notices required pursuant to C.G.S. Sec. 19a-175 through Sec. 19a-199, inclusive, and any regulations promulgated thereunder;
- (7) For licensed service only, payment of the one hundred dollar (\$100.00) annual fee imposed by C.G.S. Sec. 19a-180. The renewal application shall be signed by the chief executive officer.

(c) Issuance and renewal of licenses or certificates.

(1) Upon determination by OEMS that an applicant is in compliance with all applicable statutes and regulations, OEMS shall issue a license or certificate, or a renewal of license or certificate, to operate the service for a period not to exceed twelve (12) months.

(2) A license or certificate shall be issued in the name of the service applying for a license or certificate.

(3) The license or certificate shall not be transferable to any other person or service except as provided by Sec. 19a-180-1 through Sec. 19a-180-10, inclusive, of the Regulations of Connecticut State Agencies.

(d) Change in status.

(1) Any change of ownership, services provided, number of vehicles or location shall require a new license or certificate to be issued. The licensee or certificate holder shall apply to OEMS in writing prior to the implementation of any such change.

(2) Any change in other information required by Sec. 19a-179-5 (b) (1) through (6), inclusive shall be reported to OEMS within ten (10) business days of the implementation of any such change.

(e) Change of Ownership for emergency medical service organizations holding a primary service area.

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(1) The intended purchaser of any licensed or certified emergency medical service organization holding a primary service area shall:

(A) At least 30 days prior to the intended date of purchase, provide the Department with a written notice of intent to purchase said business.

(B) Complete an “Intent to Purchase” form provided by the Department, which shall include, at a minimum, the following:

(i) Name of business to be purchased;

(ii) A detailed description of what is included in the transaction;

(iii) A description of the geographic boundaries of the Primary Service Area(s) served by the business to be purchased;

(iv) Attestation from the purchaser and the chief administrative official of the municipality in which the Primary Service Area lies, on forms provided by the Department. Said attestation shall indicate that the purchaser has agreed to meet or exceed the performance standards to which the purchased emergency medical service organization was obligated pursuant to its agreement with the municipality. A separate attestation form shall be used for each municipality included in the transaction.

(C) Comply with all state laws and regulations governing licensing or certification of emergency medical services organizations.

(2) A change of ownership of any licensed or certified emergency medical service organization shall not occur unless all provisions of this section are met.

(Effective June 14, 1988; Amended September 27, 2001)

Sec. 19a-179-6. When license or certification not required

When an ambulance service which is operated from a location or headquarters outside the State of Connecticut provides emergency medical services inside of the State of Connecticut, no license or certificate shall be required of the service or its personnel under C.G.S. Sec. 19a-180 with respect to the following activities of such ambulance service:

(a) Transporting a patient from a location outside the state to a location within the state; or,

(b) Transporting a patient from a location within the state to location outside the state; or,

(c) Utilization within Connecticut for assistance during times of mutual aid mass casualty or disaster situations; or,

(d) Responding in this state in accordance with a written mutual aid agreement which has been approved by OEMS.

(Effective June 14, 1988)

Sec. 19a-179-7. Records

(a) Each licensed or certified emergency medical service shall maintain for a period of at least five (5) years, records on each person employed by the service in a paid or unpaid capacity. Such records shall include at least the following information:

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- (1) Name;
 - (2) Address and telephone number;
 - (3) Type and date of training; and,
 - (4) Certification levels, including date of issuance and renewal.
- (b) Each licensed and certified emergency medical service shall maintain, for a period of at least seven (7) years, records on each request for service. Such record shall include at least the following information:

- (1) Name;
 - (2) Date;
 - (3) Time of notification;
 - (4) Time of response;
 - (5) Location of response;
 - (6) Time of arrival at scene;
 - (7) Patient condition upon arrival for emergency patients;
 - (8) Treatment rendered;
 - (9) Destination location; and,
 - (10) Time of arrival at destination;
- (c) Licensed and certified emergency medical service providers shall maintain all business records, including those required to be maintained by this section, at the business location set forth on the most recent licensure or certification application or renewal form.
- (d) All records maintained by a licensed or certified emergency medical services provider, including those required to be maintained by this section, shall be subject to routine inspection by the OEMS upon reasonable notice to the service. In cases involving investigations by the OEMS, such records shall be made available to the OEMS during normal business hours, without prior notice. The failure to grant OEMS access to such files shall be grounds for suspension or revocation of a license or certificate.

(Effective June 14, 1988)

Sec. 19a-179-8. Accident reports

Each ambulance service or invalid coach service shall report to OEMS, in writing, within ten (10) business days of occurrence, any accident which has been deemed by the law enforcement agency or primary jurisdiction to be the fault of the service or which has resulted in personal injury, or property damage estimated to be in excess of six hundred dollars (\$600.00), or both. Such report shall include a copy of the accident investigation report by the investigating law enforcement officer or a copy of the report filed with the Connecticut department of motor vehicles by the driver of the vehicle involved.

(Effective June 14, 1988)

Sec. 19a-179-9. Specifically prohibited acts

(a) No person acting as an emergency medical service provider shall possess or carry dangerous weapons such as firearms, night sticks, explosive devices or knives with blades

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over four (4) inches long in an emergency medical service vehicle. This provision shall not apply to sworn law enforcement officers while on duty as such.

(b) No person acting as an emergency medical service provider shall possess or carry handcuffs. Nor shall any person possess or carry any other restraint devices except those approved by OEMS in accordance with subsection 19a-179-18 (a) (2) (R) of these regulations. This provision shall not apply to sworn law enforcement officers while on duty as such.

(c) No person shall smoke in the patient compartment of an emergency medical service vehicle.

(d) No person, organization, association or entity shall represent itself as being recognized by the OEMS unless it has in its possession a current certificate or license issued by OEMS.

(e) No person shall represent herself or himself to be an “MRT,” “medical response technician,” “EMT,” “emergency medical technician,” “intermediate” or “paramedic” unless she or he is currently certified as such by OEMS in accordance with these regulations.

(f) No person engaged in the provision of emergency medical services shall commit an act which is detrimental to the safety, health, or welfare of a patient or the general public.

(g) No person, acting as part of the emergency medical services system, shall perform treatment methods unless she or he is certified by the OEMS at a level which allows such performance.

(h) No person, acting as part of the emergency medical services system, shall perform treatment methods beyond that for which the responding service is certified.

(i) No person, regardless of certification, shall independently perform treatment methods identified in Sec. 19a-179-12 (b) unless acting as part of the emergency medical services system, in accordance with Sec. 19a-179-12.

(Effective June 14, 1988)

Sec. 19a-179-10. Categorization of and staffing requirement for services

(a) **First Responder.** A first responder service shall have the capability of providing at least the following at the scene of each EMS call to which it responds:

(1) Personnel

(A) One medical response technician (MRT) who:

(i) Is certified in accordance with Sec. 19a-177-16 (a) of these regulations; and

(ii) Has the ability to respond to EMS calls with a two-way radio compatible with the first responder service dispatcher.

(2) Supplies.

(A) Bandaging material and dressing sufficient to control hemorrhage;

(B) Oropharyngeal or mouth-to-mouth airways in infant, child and adult sizes. Such airways shall be nonrigid and nonmetal in construction;

(C) Portable oxygen administration apparatus with 30 minutes supply at 7 lpm flow rate, which is operable totally detached from the parent vehicle. Such unit shall be capable of

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accepting attachment to a nasal cannula, mouth/nose mask or as enrichment feed to a forced ventilation unit.

(b) **Basic Ambulance Service.** A basic ambulance service shall have the capability of providing at least the following at the scene of each EMS call to which it responds:

(1) Minimum Personnel

(A) One medical response technician (MRT) who is certified in accordance with Sec. 19a-179-16 (a) of these regulations; and

(B) One emergency medical technician (EMT) who:

(i) Is certified in accordance with Sec. 19a-179-16 (b) of these regulations; and

(ii) Shall attend the patient in the patient compartment of the ambulance at all times.

(2) Basic ambulance service vehicles shall comply with Sec. 19a-179-18 (a) of these regulations.

(c) **Mobile Intensive Care—Intermediate Level—(MIC-I).** A MIC-I level shall have the capability of providing at least the following at the scene of each EMS call to which it responds.

(1) One emergency medical technician (EMT) who is certified in accordance with Sec. 19a-179-16 (a) of these regulations

(2) One emergency medical technician—intermediate (EMT-I) who:

(A) Is certified in accordance with Sec. 19a-179-16 (c) of these regulations; and

(B) Shall attend the patient in the patient compartment of the ambulance at all times.

(3) MIC—Intermediate level vehicles shall comply with Sec. 19a-179-18 (b) of these regulations.

(d) **Mobile Intensive Care—Paramedic Level—(MIC-P).** A MIC-P service shall have the capability of providing at least the following at the scene of each EMS call to which it responds:

(1) A minimum of one (1) basic EMT, certified in accordance with Sec. 19a-179-16 (b) of these regulations, and one (1) EMT-P, certified in accordance with Sec. 19a-179-16 (c) of these regulations. The EMT-P shall provide advanced level skills; and

(2) MIC-P service vehicles shall comply with Sec. 19a-197-18 (b) of these regulations.

(e) **Invalid Coaches.** An invalid coach service shall have the capability of providing at least the following for each request for service to which it responds.

(1) Within ninety (90) days of effective date of these regulations, a minimum of one person trained in CPR in accordance with standards of the American Heart Association or the American Red Cross, and who may also serve as the driver.

(2) An invalid coach vehicle shall comply with Sec. 19a-179-18 (c) of these regulations.

(f) A service may be licensed/certified in one or more categories of service.

(Effective June 14, 1988)

Sec. 19a-179-11. Availability of response services

Each basic ambulance service and mobile intensive care service shall be prepared to respond to calls for emergency services originated from an EMS dispatch center for its

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primary service area on a 24 hour a day, 7 day a week, basis, or arrange with other certified or licensed response services to offer coverage for its PSA during nonoperational hours with no reduction in level of service. If such arrangement with other services is necessary, a copy of a written agreement between the services to that effect shall be enclosed in the response service's application, described in Sec. 19a-179-5 of these regulations. The following requirements shall be followed in carrying out the requirement set forth above:

(a) If a service has only one ambulance in operation or only one crew available to respond to calls, and the service is the only service within a municipality, that ambulance and crew shall be reserved for emergency calls within the service's PSA, or for calls for mutual aid.

(b) If a service has only one ambulance in operation but there are other licensed or certified services based within the municipality, the service may use its only ambulance for rendering service other than emergencies only if the service first determines that there is an ambulance and crew available from the other service within the municipality to respond to emergencies.

(c) If a service has only one ambulance in operation but there is a written mutual aid agreement in effect for basic ambulance coverage from an adjacent PSA service and there is a designated first responder service in the municipality, the service may make its only vehicle available for rendering service other than emergencies.

(d) Each response service shall maintain contact with the dispatch center concerning the location and availability of system vehicles.

(Effective June 14, 1988)

Sec. 19a-179-12. Mobile intensive care services (MICS): MICS authorization for patient treatment and establishment of mobile intensive care services

(a) Establishment of Mobile Intensive Care Services

(1) A proposal for the establishment of a mobile intensive care service (MICS) shall be submitted to OEMS at least 45 days prior to its anticipated implementation. This proposal must contain:

(A) A plan identifying the relationship between the MICS applicant and the sponsor hospital. This relationship shall be documented by a written agreement between the MICS applicant and the hospital's chief executive officer, and the proposal shall include a copy of this agreement. This agreement shall specifically include the standards for MIC personnel and programs set forth in Secs. 19a-179-10, 19a-179-16 and 19a-179-17 of these regulations.

(B) A statement that the MICS will provide adequate and qualified personnel to ensure that the MICS will be continuously available on a 24 hour a day, 7 day a week, basis.

(2) OEMS will notify the appropriate regional council within five (5) days of receipt of an MICS application. Each regional council will consider the application and make its recommendations to OEMS within forty (40) days. Where a regional council recommendation is not adopted, OEMS will provide written comments to the appropriate regional council.

(3) MIC activities shall be subject to medical control and direction by sponsor hospitals.

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(4) MIC personnel shall be under the supervision and direction of a physician at the sponsor hospital from which they are receiving medical direction.

(5) MIC services shall be under the control of the MIC medical director, or his or her designee, such as an on-line emergency department staff member.

(6) To be approved by the OEMS as a sponsor hospital, a hospital must:

(A) Be licensed under C.G.S. Sec. 19a-490 through Sec. 19a-493, inclusive;

(B) Appoint an emergency department staff person as liaison to the MIC personnel;

(C) Have two-way radio communications system interface with the capability to provide prehospital medical direction;

(D) Appoint an MIC medical director who shall be responsible for the following:

(i) Appropriateness of current operating protocols.

(ii) Assurance of medical supervision and training of MIC personnel.

(iii) Review of MIC personnel medical performance.

(iv) Withholding of medical authorization and the recommendation of suspension of MIC personnel from the system when in the interest of patient care, in accordance with Sec. 19a-179-15 (c) of these regulations on licensure and certification.

(7) Each sponsor hospital must provide OEMS with documentation that shall include:

(A) A description of the role that the hospital is to have in the MIC system.

(B) A description of the procedures to be followed by MIC personnel in obtaining medical direction.

(C) The treatment protocols to be used.

(D) Procedure for modification of treatment protocols.

(E) A description of the quality assurance function.

(8) Upon completion of the requirements of subdivisions (5) and (6) above, OEMS shall approve the hospital as a sponsor hospital. Such approval shall continue so long as:

(A) The hospital continues to meet the requirements of subdivision (5) above, and

(B) The hospital notifies OEMS of any changes in the information supplied to OEMS pursuant to subdivision (6) above within thirty (30) days thereof.

(9) Any service providing mobile intensive care on the effective date of these regulations shall have twelve (12) months to comply with these regulations.

(b) MICS Authorization for Patient Treatment

(1) Certified MIC personnel functioning with an approved MICS are authorized to perform the following medical care treatments under medical control:

(A) EMT–Intermediates (EMT-I’s) may:

(i) Administer intravenous solutions.

(ii) Apply pneumatic antishock garment.

(iii) Perform pulmonary ventilation by esophageal obturator airway or esophogeal-gastric tube airway.

(B) EMT–Paramedics (EMT-P’s) may:

(i) Administer intravenous solutions.

(ii) Perform pulmonary ventilations by intubation.

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- (iii) Apply pneumatic antishock garment.
- (iv) Administer parenteral medication included in approved protocols.
- (v) Perform cardiac defibrillation.
- (vi) Perform other procedures and treatments as indicated by patient need when consistent with training and ability and protocols.

(2) Persons other than certified MIC personnel who function with an approved MICS may be authorized to perform any of the medical care treatments under medical control set forth in subsection (b) (1) above provided that:

- (A) all other criteria of this section are met; and,
- (B) prior application is made and written approval of OEMS is obtained based on its determination that such personnel can perform said treatments at least as proficiently as persons who are certified.

Such persons shall be registered but not certified by OEMS.

(3) Prior to licensure or certification, a MICS must submit a roster of its mobile intensive care personnel to its sponsor hospital and to OEMS. The roster must be corrected as changes occur.

(c) Any service licensed or certified on the effective date of these regulations shall have twelve (12) months to comply with Sec. 19a-179-12 (a) of these regulations.

(Effective June 14, 1988)

Sec. 19a-179-13. Release of care to physician on scene

EMS personnel may release patient care responsibility to an on-scene physician only after:

- (a) The physician has been identified as a Connecticut licensed physician and has offered some form of identification, such as a driver's license, which confirms the credentials; and,
- (b) Obtaining from the physician a commitment to accompany the patient to the hospital in the vehicle transporting the patient; and,
- (c) Having the physician speak directly to the person responsible for medical direction and receiving authority to release the patient.

(Effective June 14, 1988)

Sec. 19a-179-14. Personnel equivalency

(a) EMT personnel are qualified and authorized to perform the functions of MRT personnel.

(b) EMT-I, and EMT-P personnel are qualified and authorized to perform the functions of EMT personnel.

(Effective June 14, 1988)

Sec. 19a-179-15. Reprimand, suspension, revocation of a license or certificate

(a) The commissioner of health services, after a hearing, may issue a written reprimand to, or suspend or revoke a license or certificate of, any emergency medical services provider,

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or may temporarily or permanently suspend from practice any emergency medical service provider in any case in which he finds that there has been a substantial failure to comply with the requirements established under C.G.S. Secs. 19a-175, to 19a-199, inclusive, and these regulations, or in which he finds that the provider has failed to maintain the standards of the emergency medical services profession. Notice of such hearing to the holder of a license or certificate shall be effected by registered or certified mail or by personal service, setting forth the particular reasons for the proposed action and fixing a date, not less than thirty days from the date of such mailing or service, at which the holder of such license or certificate shall be given an opportunity for a hearing. Such hearing may be conducted by the commissioner of health services, a deputy commissioner, or by a member of the department of health services designated by said commissioner. On the basis of such hearing, or upon default of the holder of such license or certificate, the person conducting such hearing shall specify his findings and conclusions, and said department may, upon the basis of such findings and conclusions, revoke or suspend the license or certificate or take any interaction it deems necessary. A copy of such decision shall be sent by registered or certified mail or served personally upon the holder of such license or certificate. The procedure governing hearings authorized by this section shall be in accordance with C.G.S. Secs. 4-177 to 4-182, inclusive, and with Secs. 19-2a-1 to 19-2a-41, inclusive, of the Regulations of Connecticut State Agencies. A full and complete record shall be kept of all proceedings. A copy or copies of the transcript may be obtained by any interested party on payment of the cost of preparing such copy of copies.

(b) A MIC medical director may withhold medical authorization from, and may recommend to OEMS and the regional medical director the removal from practice of, any MIC level personnel or service when such personnel or service act in a manner which evidences incompetence, negligence, or otherwise poses a threat to public health or safety or which is contrary to medical direction.

(Effective June 14, 1988)

Sec. 19a-179-16. Repealed

Repealed December 29, 2000.

Sec. 19a-179-16a. Minimum personnel qualifications - certification and licensure

(a) Medical Response Technician.

(1) In order to qualify for initial medical response technician certification, or for current certification of a lapsed certificate, an applicant shall meet one of the following requirements: (A) successfully complete, within twelve months of the date of application for certification, a training program, which if offered outside Connecticut, adheres to a United States Department of Transportation, National Highway Traffic Safety Administration, First Responder National Standard Curriculum and includes an examination. A training program offered in Connecticut shall be approved by the Department pursuant to section 19a-179-17 of the Regulations of Connecticut State

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Agencies and shall include an examination approved by the Department; (B) hold current certification as a person entitled to perform similar services under a different designation by the National Registry of Emergency Medical Technicians or its successor organization as approved by the Department, or by a state which maintains certification requirements equal to or higher than those in this state; or (C) have held emergency medical technician certification pursuant to section 19a-179-16a(b) of the Regulations of Connecticut State Agencies or emergency medical technician-intermediate pursuant to section 19a-179-16a(c) of the Regulations of Connecticut State Agencies or paramedic licensure pursuant to chapter 384d of the Connecticut General Statutes and completed the examination required in subparagraph (A) of this subdivision.

(2) In order to qualify for recertification an applicant shall meet the following requirement:

(A) complete a minimum of fifteen hours of refresher training, approved by the Department pursuant to section 19a-179-17 of the Regulations of Connecticut State Agencies, at intervals not to exceed twenty-four months for the period starting with the date of the initial certification and extending through the end of the sixth consecutive year of certification. Starting in the seventh year of certification and thereafter, an applicant shall complete fifteen (15) hours of refresher training, approved by the Department pursuant to section 19a-179-17 of the Regulations of Connecticut State Agencies, at intervals not to exceed thirty-six months. Refresher training programs shall include both written and practical testing; (B) individuals may complete one out-of-state refresher training program throughout the lifetime of the certificate which may be accepted in lieu of a refresher training program required pursuant to section 19a-179-16a(a)(2)(A) of the Regulations of Connecticut State Agencies provided: (i) the individual is currently certified as a medical response technician or as a person entitled to perform similar services under a different designation in another state; (ii) the refresher training program is equal to the refresher training program required pursuant to section 19a-179-16a(a)(2)(A) of the Regulations of Connecticut State Agencies; and (iii) the refresher training program is approved by the appropriate regulatory body of such other state.

(3) No certificate shall be issued to a person applying for certification pursuant to section 19a-179-16a(a)(1) of the Regulations of Connecticut State Agencies against whom a complaint is pending adjudication in another state or with the Department of Public Health.

(b) Emergency Medical Technician

(1) In order to qualify for initial emergency medical technician certification, or for current certification of a lapsed certificate, an applicant shall successfully complete a written and practical examination prescribed by the Department and meet one of the following requirements: (A) successfully complete a training program which, if offered outside Connecticut, adheres to the United States Department of Transportation, National Highway Traffic Safety Administration, Emergency Medical Technician National Standard Curriculum. A training program offered in Connecticut shall be approved by the Department pursuant to section 19a-179-17 of the Regulations of Connecticut State Agencies; (B) hold

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current certification to perform similar services under a different designation by the National Registry of Emergency Medical Technicians or its successor organization as approved by the Department, or by a state which maintains certification requirements equal to or higher than those in this state; or (C) hold a current unrestricted Connecticut registered nurse, advanced practice registered nurse, physician/surgeon, or physician assistant license and complete a minimum of twenty-five (25) hours of refresher training, approved by the Department pursuant to section 19a-179-17 of the Regulations of Connecticut State Agencies.

(2) In order to qualify for recertification, an applicant shall meet one of the following requirements: (A) complete a minimum of twenty-five (25) hours of refresher training, approved by the Department pursuant to section 19a-179-17 of the Regulations of Connecticut State Agencies, at intervals not to exceed twenty-four months for the period starting with the date of the initial certification and extending through the end of the sixth consecutive year of certification. Starting in the seventh year of certification and thereafter, an applicant shall complete twenty-five (25) hours of refresher training, approved by the Department pursuant to section 19a-179-17 of the Regulations of Connecticut State Agencies, at intervals not to exceed thirty-six months. Such refresher training programs shall include both written and practical testing; (B) successfully complete the examination required pursuant to section 19a-179-16a(b)(1) of the Regulations of Connecticut State Agencies at intervals not to exceed twenty-four months for the period starting with the date of the initial certification and extending through the end of the sixth consecutive year of certification. Starting in the seventh year of certification and thereafter, an applicant shall complete the examination required pursuant to section 19a-179-16a(b)(1) of the Regulations of Connecticut State Agencies, at intervals not to exceed thirty-six months; (C) individuals may complete one out-of-state refresher training program throughout the lifetime of the certificate which may be accepted in lieu of a refresher training program required pursuant to section 19a-179-16a(b)(2)(A) of the Regulations of Connecticut State Agencies provided: (i) the individual is currently certified as an emergency medical technician or as a person entitled to perform similar services under a different designation in another state; (ii) the refresher training program is equal to the refresher training program required pursuant to section 19a-179-16a(b)(2)(A) of the Regulations of Connecticut State Agencies; and (iii) the refresher training program is approved by the appropriate regulatory body of such other state; or (D) an applicant who is certified as an emergency medical services-instructor issued pursuant to section 19a-179-16a(d) of the Regulations of Connecticut State Agencies may qualify for recertification as an emergency medical technician provided such emergency medical services-instructor served as an emergency medical services-instructor within two years of application for recertification, for the required modules of a training program required pursuant to section 19a-179-16a(b)(1)(A) of the Regulations of Connecticut State Agencies or section 19a-179-16a(b)(2)(A) of the Regulations of Connecticut State Agencies or equivalent modules in any Department-approved initial or refresher course.

(3) No certificate shall be issued to a person applying for certification pursuant to section

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19a-179-16a(b)(1) of the Regulations of Connecticut State Agencies against whom a complaint is pending adjudication in another state or with the Department of Public Health.

(c) Emergency Medical Technician-Intermediate

(1) In order to qualify for initial emergency medical technician-intermediate certification, or for current certification of a lapsed certificate, an applicant shall successfully complete, within one year of date of application, an examination prescribed by the Department, and meet the following requirements: (A) hold current emergency medical technician certification issued pursuant to section 19a-179-16a(b) of the Regulations of Connecticut State Agencies and successfully complete a training program which, if offered outside Connecticut, includes those modules of a United States Department of Transportation, National Highway Traffic Safety Administration, Emergency Medical Technician-Intermediate National Standard Curriculum required by the Department or if offered in Connecticut, shall be approved by the Department. A training program offered in Connecticut must be approved by the Department pursuant to section 19a-179-17 of the Regulations of Connecticut State Agencies; or (B) hold current certification to perform similar services under a different designation by the National Registry of Emergency Medical Technicians or its successor organization as approved by the Department, or by a state which maintains certification requirements equal to or higher than those in this state.

(2) In order to qualify for recertification, an applicant shall meet the following requirements: (A) complete a minimum of twenty-five (25) hours of refresher training required pursuant to section 19a-179-16a(b)(2)(A) of the Regulations of Connecticut State Agencies and approved by the Department pursuant to section 19a-179-17 of the Regulations of Connecticut State Agencies, at intervals not to exceed twenty-four months. Such refresher training programs shall include both written and practical testing; and (B) complete a minimum of twenty-three (23) credit hours of continuing education at intervals not to exceed twenty-four (24) months. Such twenty-three (23) hours shall include, but not be limited to, coursework in intravenous techniques and advanced airway management. One credit hour shall mean a minimum of sixty (60) minutes of live instruction which a participant physically attends, either individually or as part of a group. (C) Each certified emergency medical technician-intermediate shall maintain written documentation of completion of continuing education activity for a period of four years. Said documentation may be maintained by the sponsor hospital or emergency medical services provider with which such certificate holder is affiliated or employed. The Department may inspect such certificate holder records as it deems necessary. Such documentation shall be submitted to the Department only upon the Department's request to the certificate holder. The certificate holder shall submit such records to the Department within forty-five days of the Department's request.

(3) No certificate shall be issued to a person applying for certification pursuant to section 19a-179-16a(c)(1) of the Regulations of Connecticut State Agencies against whom a complaint is pending adjudication in another state or with the Department of Public Health.

(d) Emergency Medical Services-Instructor

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(1) In order to qualify for initial emergency medical services-instructor certification, or for current certification of a lapsed certificate, an applicant shall apply on forms prescribed by the Department and shall meet the following requirements: (A) hold current emergency medical technician certification issued pursuant to section 19a-179-16a(b) of the Regulations of Connecticut State Agencies or Emergency Medical Technician-Intermediate certification issued pursuant to section 19a-179-16a(c) of the Regulations of Connecticut State Agencies or Paramedic licensure issued pursuant to section 20-206// of the Connecticut General Statutes; (B) be recommended by a Connecticut Emergency Medical Services Regional Council or Connecticut State Agency. In order to obtain such Regional Council or Connecticut State Agency recommendation, the applicant shall submit to the regional council or Connecticut State Agency: (i) a letter of endorsement, signed by two currently certified emergency medical services-instructors documenting that the applicant has completed, under the supervision of such instructors, at least twenty-five (25) hours of student teaching in courses approved pursuant to section 19a-179-17 of the Regulations of Connecticut State Agencies; (ii) documentation that the applicant has a minimum of twenty-four (24) months of emergency medical service, within thirty-six (36) months of the date of application, with an ambulance or rescue organization or in the emergency medical care field as approved by the Department; (iii) evidence that the applicant satisfactorily completed, within the previous twelve (12) months, the written examination required pursuant to subdivision (1) or (2) of subsection (b) of this section. The pass point for EMS-I applicants shall be prescribed by the Department; and (C) shall comply with one of the following: (i) successfully complete a Department approved emergency medical services instructor course, or its equivalent as approved by the Department. Application for emergency medical services instructor certification must be made to the Department within two years of completing an approved instructor course or its equivalent; or (ii) individuals who have successfully completed an approved emergency medical services instructor course or its equivalent as approved by the Department, more than two years prior to the date of application for emergency medical services instructor certification, shall provide evidence of at least fifty (50) hours of teaching experience every two years since completion of the course, on forms provided by the Department.

(2) In order to qualify for recertification, an applicant shall meet the following requirements: (A) satisfactorily accrue a minimum of fifty (50) contact hours consisting of attendance at approved continuing education courses and instruction of approved EMS courses within the prior twenty-four (24) month period. The fifty (50) contact hours shall include a minimum of thirty-five hours of teaching in at least five different topics of a training program approved pursuant to section 19a-179-17 of the Regulations of Connecticut State Agencies, and a minimum of five hours attained by attending continuing education approved by the Department. (B) Each certified emergency medical services-instructor shall maintain written documentation of completion of the requirements prescribed pursuant to section 19a-179-16a(d)(2)(A) of the Regulations of Connecticut State Agencies for a period of four years. The Department may inspect such certificate holder records as it deems

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necessary. Such documentation shall be submitted to the Department only upon the Department's request. The certificate holder shall submit such records to the Department within forty-five (45) days of the Department's request. (C) Maintain current certification as an emergency medical technician pursuant to section 19a-179-16a(b)(2) of the Regulations of Connecticut State Agencies or as an emergency medical technician-intermediate pursuant to section 19a-179-16a(c)(2) of the Regulations of Connecticut State Agencies or maintain licensure as a Paramedic pursuant to section 20-20611 of the Connecticut General Statutes.

(3) No certificate shall be issued to a person applying for certification pursuant to section 19a-179-16a(d)(1) of the Regulations of Connecticut State Agencies against whom a complaint is pending adjudication in another state or with the Department of Public Health.

(e) Paramedic.

(1) In order to qualify for paramedic licensure an applicant shall meet the requirements of Chapter 384d of the Connecticut General Statutes.

(2) The training program, as used in section 20-206mm(a) of the Connecticut General Statutes, means a program that, if offered outside Connecticut, is equal to or exceeds a training program adhering to the United States Department of Transportation, National Highway Traffic Safety Administration, Paramedic National Standard Curriculum. Training programs offered in Connecticut shall be approved in advance by the Department pursuant to section 19a-179-17 of the Regulations of Connecticut State Agencies.

(3) Reinstatement. A person previously licensed as a paramedic whose license has become void pursuant to section 19a-88 of the Connecticut General Statutes, may apply for licensure pursuant to the provisions of section 19a-14-1 to 19a-14-5, inclusive, of the Regulations of Connecticut State Agencies.

(Adopted effective December 29, 2000)

Sec. 19a-179-17. EMS training programs

(a) In order to conduct an OEMS-approved training program for any classification set forth in Sec. 19a-179-16 of these regulations, a person must:

(1) Deliver to OEMS at least thirty (30) days prior to the planned initiation of the program a written application to conduct said training program on a form prescribed by OEMS. Such application shall include, but is not limited to, the following information:

(A) A list of teaching facilities to be used, and of available teaching aids and supplies.

(B) A proposed list of instructors, assistant instructors, and physician lecturers to be used during the course of the program.

(C) A statement of compliance that the program meets the most recent National Standard Training Curriculae, as approved by the United States Department of Transportation, National Highway Safety Traffic Administration, for the appropriate category.

(2) Ensure that there is a state-certified EMS-I responsible for all class sessions.

(3) Follow the training manual developed by OEMS, as kept current and on file at OEMS, and made available to the general public.

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(4) Maintain complete financial and administrative records for inspection by OEMS.

(b) OEMS shall approve or disapprove such training program proposal applications and notify the appropriate regional council within twenty (20) days of the delivery of the proposal to OEMS. Prior to approval, OEMS shall consult with the regional EMS coordinator for his/her recommendation. Where a regional EMS coordinator's recommendation is not adopted, the OEMS will provide written comments to the regional EMS coordinator.

(c) To enroll in an OEMS-approved training program for any classification set forth in Sec. 19a-179-16 of these regulations as a student/trainee, an individual must apply to the person conducting the program in a form and manner set forth by the OEMS. Applicants who have not attained the age of eighteen shall submit with their application a consent form, prescribed by OEMS, which had been signed by a legal guardian.

(Effective June 14, 1988)

Sec. 19a-179-18. Minimum vehicle standards

(a) Basic ambulance vehicles shall be inspected at least annually by OEMS and shall conform to the following design and equipment standards:

(1) Design.

(A) Minimum 60" head room in patient compartment measured from floor aisle space to head liner.

(B) Minimum 114" interior length in patient compartment from inside back door to rear of driver's compartment.

(C) Minimum 12" unobstructed aisle space bet primary patient stretcher and any obstruction for full length of primary patient stretcher on one side.

(D) Ability to achieve and maintain an average patient compartment temperature of 65°–70° regardless of weather conditions.

(E) Electrical intercom or signal lights or an open partition to permit exchange of patient condition information between patient compartment and driver.

(F) Sufficient secure storage to permit secure loading and confinement of all items which could move freely about patient area in the event of a collision or roll over.

(G) Rotating or flashing warning lights visible 360° about vehicle.

(H) Mechanical and/or electrical siren.

(I) Two-way radio communications that are compatible with the state approved communications system and will allow communicating with communications coordinating centers (e.g. regional communications centers, central emergency medical dispatch), dispatch and/or directly to the hospital.

(J) Exterior identification visible on two opposite sides of vehicle showing the name of the service the vehicle is operated by.

(K) Any basic ambulance vehicle shall meet or exceed the design criteria of General Services Administration Specifications KKK-A-1822, as amended, with the following exceptions and/or substitutions [Federal specification number shown in parenthesis ()]:

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- (i) Spare tire (3.6.10)
- (ii) Tire changing tools (3.6.3)
- (iii) Engine high idle speed control, automatic (3.7.6.1)
- (iv) Internal 12 volt d.c. power (3.7.7.3)
- (v) 115 volt a.c. utility power (3.7.8)
- (vi) Utility power connector (3.7.8.1) - optional
- (vii) Electrical 115 volt a.c. receptacles (3.7.8.2)
- (viii) Solid state inverter (3.7.8.3)
- (ix) Override front bumpers (3.9.6.1)
- (x) Interior storage accommodations (3.11.3)
- (xi) Exterior storage accommodations (3.11.1)
- (xii) Extrication equipment and storage (3.11.2.1)
- (xiii) Storage compartments and cabinet design transparent doors (3.11.3)
- (xiv) Color, paint and finish (3.16.2)
- (xv) Color standards and tolerances (3.16.2.1)
- (xvi) Emblems and markings (3.16.4)—substitute the following:
 - a. Front of vehicle—the word “AMBULANCE” in block, reflectorized letters, not less than four inches high shall be mirror image, centered above the grill.
 - b. Sides and rear of vehicle—the word “AMBULANCE” shall be in block, reflectorized letters, not less than six inches high, centered on each side and rear of vehicle body.
- (xvii) Rustproofing (3.18)
- (xviii) “Star of Life” (4.3)
- (xix) Intended Use (6.1)
- (2) Equipment
 - (A) Oxygen administration apparatus with 2 hours supply at 7 lpm flow rate, regulator controlled flow rate permitting adjustment from a minimum of 2 lpm–10 lpm with visual indication of flow rate. Adaptors so that a minimum of 2 patients may be provided O₂ at the same time. A minimum of 2 each, nasal cannulas and mouth/nose masks.
 - (B) Portable oxygen administration apparatus with 30 minutes supply at 7 lpm flow rate, which is operable totally detached from parent vehicle. Such unit shall be capable of accepting attachment to a nasal cannula, mouth/nose mask or as enrichment feed to a forced ventilation unit.
 - (C) Suction apparatus capable of drawing a vacuum of 300mm of mercury. Such unit shall be operable completely independent of parent vehicle for a minimum period of 15 minutes. Such suction apparatus shall be compatible with both rigid and flexible catheters and a minimum of 1 catheter and 1 spare shall be carried.
 - (D) Mechanical forced resuscitation unit which is either hand operated (bag mask) or cycled only by operator manual control. Pressure cycles units are not acceptable. Such unit shall be compatible with O₂ apparatus carried in the subject vehicle for purposes of oxygen enrichment. Such unit shall be compatible with infant, child and adult masks which shall be made of transparent material and shall be carried.

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(E) Nonrigid, mouth-to-mouth, oropharyngeal airway maintenance devices in infant, child and adult sizes. A minimum of 1 and 1 spare for each size.

(F) Bite stick for maintaining an open-jawed position on an unconscious patient.

(G) A minimum of six large dressings of the ABD or multi-trauma type.

(H) Assorted dressings and bandages to facilitate hemorrhage control by direct pressure bandage on any area of the human body regardless of severity of hemorrhage.

(I) Aluminum foil, sterile vaseline gauze or other air excluding dressing material to permit air tight seal of wounds to the chest cavity.

(J) Two sterile sheets for isolating burn patients from external sources of contamination.

(K) A splinting device suitable for providing prolonged traction to a lower limb on a child or adult.

(L) Splinting material to permit immobilization and protection to any portion of a child or adult limb in any position. A minimum of 1 spare shall be carried for each size of splint.

(M) Short extrication device (e.g. short backboard with 2 straps minimum of 9' by 2", forehead and chin restraints) to permit the immobilization of suspected cervical fracture of a child or adult patient during removal from a confined space while in a seated position and during transport.

(N) A long extrication device (long backboard with 2 straps minimum 9' by 2") to permit the immobilization and transport of a spinal column fracture without vertical or horizontal expansion, contraction or twisting. A scoop stretcher is not a suitable device for this requirement.

(O) 3 cervical immobilization collars of assorted sizes (extrication type collars are recommended).

(P) Commercial stair chair to permit the movement of a patient either up or down within a confined stairway.

(Q) Adult and pediatric blood pressure manometer and cuff, and stethoscope for determining patient blood pressure both outside and inside of vehicle.

(R) Restraint devices of sufficient strength to restrain a violent adult and sufficiently padded to prevent chafing or injury to patient.

(S) A poison treatment kit in addition to one half gallon potable water.

(T) An obstetrical kit containing a minimum of 1 pair sterile gloves, scissors, umbilical cord clamps or tapes, sterile vaginal dressings, 2 towels, large plastic bag, and swaddling material.

(U) One emesis basis, 1 bed pan and 1 urinal.

(V) Not less than 2 pillows and 2 sets of linen to include 2 sheets 2 pillow cases, and 1 blanket per set.

(W) A minimum of 2 10 lb. ABC UL fire extinguishers, 1 carried in driver compartment and 1 in patient compartment.

(X) At least two battery operated, hand carried portable lights.

(Y) One wrecking bar minimum 24" in length.

(Z) At least one cot with 2 patient securing straps. Such cot shall be removable from the

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ambulance, and provision shall be made for positive locking when the cot is positioned in the vehicle.

(AA) Glucose in a form easily ingested orally.

(BB) A rebreathing device for use in treating hyperventilation syndrome.

(CC) Highway distress signalling devices, either a minimum of 3 hours duration red burning flares, or four reflectorized road marking triangles.

(DD) Two sets of sandbags.

(EE) Disposable procedure gloves, gowns, masks, and goggles.

(3) Each basic ambulance vehicle shall display decals supplied by OEMS on the rear exterior and in the patient compartment of the vehicle indicating it is certified by OEMS. Such decal shall be easily visible in the patient compartment and on the rear exterior of the vehicle.

(4) All required equipment shall be in working order, and each crew member shall be knowledgeable in the operation of such equipment. Substitution for equipment may be made only with the prior written approval of OEMS, upon its determination that the substituted equipment will function at least as well as that which is specified in subsection (2) above.

(5) Each basic ambulance certified vehicle shall be registered by the Connecticut department of motor vehicles as an ambulance.

(b) **MIC Units shall conform to the following design and equipment standards.**

(1) Design.

(A) Compliance with all safety and design requirements of the Connecticut department of motor vehicles.

(B) Compliance with all federal requirements for vehicle safety design.

(2) Equipment.

(A) Must comply with applicable requirements for basic certification either first responder or basic ambulance.

(B) Airway maintenance equipment as defined by the RMAC and approved by OEMS.

(C) Pneumatic antishock garment.

(D) Intravenous administration sets as defined by the RMAC and approved by OEMS.

(E) Intravenous solutions in nonbreakable containers as defined by RMAC and approved by OEMS.

(F) For EMT–Paramedic units only.

(i) Laryngoscope, batteries and blades in adult and pediatric sizes.

(ii) Adult and pediatric endotracheal tubes.

(iii) Electrocardiograph monitor with the capability of making a permanent record.

(iv) Cardiac defibrillator.

(v) Blood sampling tubes.

(vi) Medications in amounts and administration methods as defined by the RMAC and approved by OEMS.

(3) All equipment including that used for invasive therapies shall be cleaned and maintained between uses to assure protection from infection in subsequent use.

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(c) Invalid Coach

(1) Vehicle Type—The vehicle is to be a van type unit of standard manufacture which meets all specifications for operations on Connecticut highways, as evidenced by registration with the Connecticut department of motor vehicles and satisfaction of the following requirements.

(2) Doors:

(A) All van type vehicles used shall be equipped with operating doors on each side of the driver's compartment.

(B) A side entrance door or doors shall be provided. These doors may be of the hinged swing double door type or sliding type single door, with a minimum opening of 40" in width and 54" in height. The door shall be equipped with a device which will activate an audible or flashing signal when the panels are not securely closed. The signal shall be clearly identifiable by the seated driver.

(C) The vehicles shall be equipped with a rear opening door or doors of the hinged type, with a minimum opening of 45" in width and 50" in height. Should the vehicle be equipped with a rear bench seat blocking the rear door, the vehicle shall be equipped with a rear bench seat quick release mechanism.

(D) Both side and rear doors shall be equipped with windows.

(3) Interior Design:

(A) The interior side walls shall be insulated with a fire resistant material and covered with suitable material at least equal to that installed by the manufacturer.

(B) The left side of the vehicle behind the driver shall be equipped with windows to be equal to the side door glazing.

(C) The floors shall be designed with $\frac{3}{4}$ plywood base and covered with a linoleum, rubberized surface, or commercial grade carpet.

(D) The vehicle shall be equipped with an operating heater and air conditioning system capable of maintaining an interior temperature of 65°–70° F for the comfort of patients.

(E) The vehicle shall be equipped with a two-way radio with the capability of communicating with a dispatcher at all times when a patient is being transported.

(F) The minimum vehicle interior height shall be 60".

(G) Each van shall be equipped with at least two (2) overhead or dome type interior lights of standard manufacture.

(H) An additional light shall be provided which illuminates the lift device or ramp area. This light shall operate automatically when the side doors are opened.

(4) Roof Design—The vehicle shall be equipped with an extended roof reinforced by rolled bars and/or cages which have been certified to withstand one and one-half times the curb weight of the unloaded vehicle.

(5) Wheelchair Lifting Device—The vehicle shall be equipped with a commercially manufactured manual ramp or an electric or hydraulic lift, which is permanently affixed to the interior of the vehicle. The ramp or lift shall be capable of supporting a minimum total load strength of 600 pounds. The lift or ramp shall be equipped with a protective flange on

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each longitudinal side, sufficient in height to prevent a wheelchair from accidentally falling off the side of the lift or ramp. The lift or ramp surface shall be composed of or covered with a non-skid material. If an electric or hydraulic lift is utilized, the lift shall also be capable of manual operation in the event of engine failure.

(6) **Wheelchair Restraining Devices**—The vehicle shall be equipped with wheelchair locking devices securely affixed to the vehicle for each wheelchair position for which the vehicle is designed. The locking device shall be capable of immobilizing the wheelchair so that it is secured in at least two places during transport with longitudinal movement not to exceed two inches forward and backward, and without any lateral movement.

(7) **Minimum Equipment:**

(A) One first aid kit.

(B) One charged fire extinguisher—at least rated 10 BC. by the Underwriter's Laboratory.

(C) Four 30 minute road flares or warning reflectors.

(D) Separate seat restraints for securing patients in wheelchairs prior to loading, in the same quantity as the maximum number of patients the vehicle is designed to accommodate.

(E) Either motion sickness bags or plastic containers with covers in sufficient number equal to the maximum number of patients the vehicle is designed to accommodate.

(F) Blankets made of nonflammable material in sufficient number equal to the maximum number of patients the vehicle is designed to accommodate.

(8) **Exterior Vehicle Identification:**

(A) Utilize the state approved handicapped sticker minimum of 4" height and located on each side of the vehicle.

(B) Exterior identification visible on each side of the vehicle identifying the service which operates the vehicle with a minimum 4" lettering.

(C) Seating capacity shall be displayed in 2" lettering at curb side of the vehicle.

(9) All replacement invalid coach vehicles shall be in compliance with these regulations.

(10) All invalid coach vehicles currently in use shall be in compliance with these regulations by January 1, 1990.

(d) Emergency medical service vehicles shall be inspected every two years by OEMS at formally designated biennial inspections in addition to unannounced inspections or at hospital spot checks of ambulance vehicles. At such inspections, the OEMS inspector shall examine the vehicle for compliance with the above requirements and may also inspect for the following:

(1) Tires – for minimum tread depth as required by the Department of Motor Vehicles or for structural damage to the body of the tire.

(2) Holes in the body of the vehicle into the driver or patient compartment.

(3) Broken or missing windows.

(4) Malfunctioning doors or door latches.

(5) Missing door seals.

(6) Missing or broken safety equipment including lights, mirrors, horns, or other devices

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required by law or regulation necessary to insure the safe operation of the vehicle.

(e) By virtue of the inspection as called for in Sec. 19a-179-18 (d) of these regulations, should an OEMS inspector determine that an ambulance vehicle is unsafe for any reason cited in the aforementioned section, the OEMS inspector shall affix a sticker to the outside of the window in the rear door which reads: "THIS VEHICLE IS UNSUITABLE FOR PATIENT TRANSPORTATION." The sticker shall be removed only by an OEMS inspector upon the reinspection of the vehicle and determination that the missing or damaged equipment has been repaired or replaced. During the period of time when the sticker is affixed to the vehicle, said vehicle shall not be used for patient transportation. The owner may request a hearing before the commissioner of health services or his designee to petition for reconsideration, stating upon what grounds such petition is based. Said hearing shall be conducted within forty-five (45) days of the request unless otherwise agreed by the requester and the commissioner.

(Effective June 14, 1988; Amended September 30, 2003)

Sec. 19a-179-19. Advertising

(a) Emergency.

(1) A provider shall not advertise emergency services by direct mailings, telephone solicitation, or other means specifically designed to solicit business unless such provider is the OEMS-approved primary service area responder in such municipality.

(2) Providers shall not advertise emergency services in print media which reaches beyond PSA boundaries unless the advertisement indicates the location from which the provider is authorized to operate by OEMS in letters at least as large as the name of the provider.

(3) Providers shall not advertise emergency services in audio or video media unless such advertisement clearly states the location from which the provider is authorized to operate by OEMS. The statement of location shall be emphasized at least as prominently as the name of the provider.

(4) Only the telephone numbers designated as primary response numbers by the council and approved by OEMS shall be placed in the emergency or community services sections of the telephone directories; any provider listing in the "yellow pages" section of telephone directories shall be in accordance with section (2) above.

(b) Other than Emergency Medical Services.

Licensed or certified emergency service providers may advertise services other than emergency and invalid coach services, provided that the word "nonemergency" is explicitly and prominently stated in the advertisement and provided that no word or expression which suggests the provision of emergency services issued. Such words or expressions which may not be used include, but are not limited to the words "emergency," "call direct," "immediate response," "eliminate delay," or "without delay".

(Effective June 14, 1988)

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Sec. 19a-179-20. Hearing

Any proceedings conducted in accordance with these regulations shall be considered a contested case under the department of health services rules of practice and procedure, Secs. 19-2a-1 through 19-2a-41, Regulations of Connecticut State Agencies.

(Effective June 14, 1988)

Sec. 19a-179-21. Rate setting for emergency medical services

Pursuant to the authority of C.G.S. 19a-177, the following regulations are enacted.

(a) Definitions

(1) “Commissioner” means the commissioner of the Connecticut department of health services, acting through the office of emergency medical services.

(2) “Department” means the Connecticut state department of health services.

(3) “Certified provider” means a municipal or volunteer ambulance service issued a certificate of operation by the office of emergency medical services.

(4) “Licensed provider” means a commercial ambulance service issued a license by the office of emergency medical services or any volunteer or municipal ambulance service issued a license by the office of emergency medical services prior to July 1, 1981.

(5) “Basic level ambulance response” means the transportation of a patient at the basic life support level.

(6) “Intermediate level ambulance response” means the transportation of a patient requiring definitive medical care by a service certified to the intravenous level.

(7) “ALS/Paramedic level ambulance response” means the transportation of a patient requiring definitive medical care by a service certified to the ALS/Paramedic level.

(8) “Invalid coach response” means a nonemergency request to transport a wheelchair patient.

(9) “Maximum allowable rate” means the highest amount which a licensed or certified provider may charge a patient for a given service in accordance with the appropriate rate schedule.

(10) “Necessary costs” means the costs directly related to the service provided.

(11) “Reasonable return on gross revenue” means that percentage of gross revenue which the commissioner allows to be earned as profits by licensed providers.

(b) The commissioner shall establish maximum allowable rates for each licensed or certified provider annually on or before December 15th of each year. Such rate shall take effect on January 1st of the following year. Certified and licensed providers may render charges which are less than maximum allowable rates.

(c) The commissioner shall set maximum allowable rate schedules for any or all of the following classifications of services:

(1) Basic level ambulance response by a certified provider;

(2) Intermediate level ambulance response by a certified provider;

(3) ALS/Paramedic ambulance response by a certified provider;

(4) Basic level ambulance response by a licensed provider;

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- (5) Intermediate level ambulance response by a licensed provider;
- (6) ALS/Paramedic level ambulance response by a licensed provider;
- (7) Invalid coach response by a licensed provider.

(d) The commissioner shall set maximum allowable charges which will allow each provider to impose the following special charges under the following conditions:

(1) Mileage. The mileage charge may be applied from the point of origin within the town of movement of a patient to any final destination other than within the town of origin. Mileage charges are not allowable when the point of origin and the point of final destination of the call are within the boundaries of the same town. Mileage shall be determined from the public utility control authority's official mileage docket no. 6770;

(2) Waiting time. Charges for waiting time may be assessed on the basis of a minimum of one hour. When waiting time is in excess of one hour, additional time may be charged in quarter hour increments;

(3) Night time. Charges may be assessed for a response between the hours of 7:00 p.m. through 7:00 a.m. the following morning;

(4) Special Attendants. Charges may be assessed for use of attendants with characteristics specifically requested by or on behalf of the patient. Such special characteristics may include, but are not limited to, special training or experience or an attendant of a specific gender. There shall be no additional charge if an attendant with the requested characteristics has already been scheduled by the ambulance provider.

(e) A certified or licensed provider shall not charge for services which are not specified in the appropriate rate schedule.

(f) Filing:

(1) On or before July 15th of each year, all licensed or certified providers shall file with the department the following financial information based upon the twelve months immediately preceeding April 30th of the year of the application:

(A) Existing rate schedule;

(B) If the provider requests a rate increase, the requested rate schedule;

(C) A complete financial statement for the twelve months immediately preceeding April 30th of the year of application, including:

(i) a statement of income and expenses on the forms provided by the department based on an accrual method of accounting;

(ii) a balance sheet indicating the condition of the business as of the close of business on April 30th of the year of application;

(iii) a review financial statement prepared in accordance with accepted accounting practices.

(D) Financial projections covering all items in subsection (f) (1) (C) of this section for the fiscal year of application reflecting the existing and requested rate schedules;

(E) A schedule of real property, transportation equipment and all other equipment owned or leased by the provider and currently in use in the provision of ambulance services;

(F) A schedule of planned capital expenditure over the next three years;

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(G) A summary by rate classification of trips logged for the immediately preceeding fiscal year;

(H) A schedule of annual compensation and benefits by job classification, including corporate officers and all employees;

(I) Numbers, job titles, annual salary ranges and hourly rate ranges of all corporate officers and employees.

(J) A schedule of any other services provided by the ambulance service provider under the same business structure;

(K) A sworn statement signed by the provider or duly authorized representative thereof that to the best of his/her knowledge the materials submitted in satisfaction of this provision are true, correct and complete and have been prepared from the books and records of the provider.

(2) Ambulance service providers shall provide the commission with any additional financial and operational information which is relevant to the rate setting; is covered under subdivision (1) of this subsection, and requested by it within fifteen (15) calendar days of receipt of the request. The request for additional information shall be made no later than August 31st of each fiscal year.

(3) Any licensed or certified provider who fails to file information required by subdivisions (1) and (2) above by July 15th of each year or within fifteen (15) days of receipt of the department's request, whichever is later, shall be subject to sanctions as provided in section 19-73bb (b), C.G.S., and shall have a maximum allowable rates for all purposes which are the lesser of the following rates:

(A) The rates set in response to the current application;

(B) The rates set following the last filing to which the providers were a party, or if none, the rates in effect at the time these regulations become effective.

(4) The department reserves the right to conduct or order a provider to conduct a full audit as it deems necessary to confirm the accuracy of submitted materials.

(g) For the purpose of the regulations, any application filed in accordance with subsection (f) of this section shall be a contested case; shall require a hearing and shall be governed by sections 19-2a-35 through 19-2a-41, inclusive of the Regulations of Connecticut State Agencies.

(h) **Waiver of right to hearing:**

(1) The applicant may waive his/her right to a hearing by filing along with the application a signed statement which indicates that:

(A) The applicant knows of his/her right to a hearing held under the provisions of sections 19-2a-35 to 19-2a-41, inclusive, of the Regulations of Connecticut State Agencies; and

(B) The applicant willingly waives the right to such hearing.

(2) Notwithstanding subdivision (1) above, the commissioner may order, not later than August 15th, that a hearing be held.

(i) All information filed by the applicant pursuant to subsections (f), (g) and (h) of this

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section shall be treated by the commissioner as a substantially complete case in support of the application.

(j) **Rate Setting Method.** In setting the maximum allowable rates for each provider, the commissioner shall consider the following:

- (1) The necessary costs incurred in providing said service;
- (2) Net income after taxes;
- (3) Utilization rate of equipment and personnel;
- (4) Increases or decreases in the United States Department of Labor consumer price index factors relevant to ambulance maintenance and operation in Connecticut, and any other relevant economic inflationary factors;
- (5) The anticipated change in cost to the provider of full compliance with new federal and state laws and regulations;
- (6) Rate differential set and paid for by other state agencies and third party payors;
- (7) The percentage of cancelled calls of the total number of calls during the preceeding fiscal year;
- (8) A reasonable return on gross revenue; and
- (9) Any other information the commissioner may deem relevant to the rate setting process.

(Effective June 14, 1988)

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Department of Health Services

Subject

Need for Emergency Medical Services

Inclusive Sections

§§ 19a-180-1—19a-180-10

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Need for Emergency Medical Services

Sec. 19a-180-1. Definitions

(a) “Applicant” means any person that proposes to implement a new or expanded emergency medical service.

(b) “New or expanded emergency medical service” means a service which is not authorized to the applicant under the terms of a current license or certificate from the Office of Emergency Medical Services, which shall include:

(1) The operation of an emergency medical, ambulance, or invalid coach service not authorized by a current license or certificate;

(2) Any service which is not authorized currently;

(3) Principal and branch places of business for an emergency medical, ambulance, or invalid coach service which are not authorized by a current license or certificate;

(4) Emergency medical vehicles, ambulances, and invalid coaches not authorized to an emergency medical, ambulance, or invalid coach service by a current license or certificate.

(c) “Office” means the Office of Emergency Medical Services.

(d) “Person” means a natural person, partnership, corporation, association or political subdivision.

(e) “Mobile Intensive Care Service” means service above basic life support which is intensive and complex prehospital care consistent with acceptable emergency medical practices under the control of physician and hospital protocols.

(Effective December 15, 1983)

Sec. 19a-180-2. Certification and licensure

No person shall implement a new or expanded emergency medical service without a license or certificate issued in accordance with sections 19a-175 through 19a-195 inclusive of the Connecticut General Statutes and an authorization issued in accordance with these regulations from the Office. Except as noted in section 19a-180-4 of these regulations, no certificate or license shall be issued to an applicant for a new or expanded emergency medical service unless the Office has determined:

(a) That the ambulance or invalid coach will be equipped in accordance with the requirements of section 19-73w-401B4a of these regulations;

(b) That numbers and training of personnel are in accordance with the requirements of section 19-73w-401B1d of these regulations;

(c) That the applicant has paid-in working capital or binding credit agreement which equals six months operating expenses in the aggregate;

(d) That the applicant has not less than the following insurance coverage currently in effect:

(1) Automotive liability and malpractice coverage for damages by reason of personal injury to, or the death of, one person, of at least five hundred thousand dollars and for damage for each incident of at least five hundred thousand dollars; and

(2) Automotive coverage for damage to property of at least one hundred thousand dollars.

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(e) That the proposed service is necessary to satisfy the emergency medical, ambulance, or invalid coach service needs of the proposed service area, which determination shall only be made after considering:

(1) The written recommendation of the regional council within whose region the proposed service would be implemented.

(A) The Office shall consult with the appropriate regional council by sending such council a copy of a completed application and a notice of hearing. The regional council recommendation shall be received by the Office at least five working days prior to the hearing required by section 19a-180-5 of these regulations. The regional council shall simultaneously send a copy of the recommendation to the applicant. Such recommendation shall be entered into evidence at the hearing as an Office exhibit.

(B) A regional council recommendation shall either support or oppose the application for the proposed new or expanded emergency medical service. The recommendation shall contain the reasons for such support or opposition.

(C) Should the regional council not act on an application and report to the Office of Emergency Medical Services within the time limits specified, the Office shall consider the application to have been approved and supported by the council.

(2) All other evidence received at a hearing held to determine the need for the proposed service.

(Effective December 15, 1983)

Sec. 19a-180-3. Application for a license or certificate for a new or expanded emergency medical service

The applicant shall apply to the Office on forms provided by the Office. The application shall be notarized and shall include the following:

(a) The name, address and nature of the legal entity that will implement the proposed service;

(b) The name, address and telephone number of the individual responsible for making application;

(c) The trade name, department, corporation, association or partnership under which the provider is or shall do business. If the provider is a corporation, name, address and title of all officers;

(d) Name of parent and associated companies if any;

(e) Type of service requested;

(f) Locations of proposed principal place of business and/or branch places of business;

(g) Locations of health facilities and other ambulance providers within the proposed area to be served;

(h) Number and types of currently authorized vehicles;

(i) Number and types of new or expanded emergency medical services being requested;

(j) Geographic area and population to be served in implementing the proposed service;

(k) Source and volume of calls over the past 12 months for a currently licensed applicant;

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- (l) Total number of calls a currently licensed applicant refused over the past 12 months, and the circumstances for refusal;
- (m) Source and volume of calls expected over the next 12 months;
- (n) Average response times over the past 12 months for a currently licensed applicant;
- (o) Evidence of paid-in working capital or binding credit agreement which equals six months operating expenses in the aggregate;
- (p) Analysis of the improvement in cost effectiveness to the provider as a direct result of the proposed service;
- (q) Analysis of how the proposed service would integrate with the current emergency medical service system;
- (r) Proof of insurance or letter of intent for new services at levels required of by section 19a-180-2(d) of these regulations; and
- (s) Any other information as may be included by the applicant;

(Effective December 15, 1983)

Sec. 19a-180-4. Volunteer ambulance services

(a) Except as provided in subsection (b) below, any volunteer ambulance service which elects to commence a new or expanded emergency medical service but which does not intend to charge for such service shall be exempt from section 19a-180-2(e) of these regulations.

(b) If such exempt provider elects to begin charging for any new or expanded emergency service implemented on or after July 1, 1980, such provider shall apply for a determination of need as required by section 19a-180-2(e) of these regulations prior to imposing a charge for such service.

(Effective December 15, 1983)

Sec. 19a-180-5. Schedule for consideration

(a) Additional materials

(1) The Office may request the filing of additional materials which are necessary to complete the application or pertinent to the determinations to be made pursuant to section 19a-180-7 of these regulations within 30 days of receipt of the application.

(2) The applicant shall submit any requested material within 10 days of receipt of such request by the Office.

(3) Failure to submit said material within the time allowed shall be deemed withdrawal of the application without prejudice to its resubmission.

(b) Hearing notice and procedure

(1) The hearing shall be conducted by the Director of the Office of Emergency Medical Services or other presiding officer designated by such Director. Such hearing shall be conducted in accordance with Chapter 54 of the Connecticut General Statutes, and sections 19-2a-35 through 19-2a-41, inclusive, of the Regulations of Connecticut State Agencies. Two or more proceedings may be heard together by the presiding officer in his discretion.

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(2) The public hearing shall be scheduled by the Office not more than sixty (60) days after the date of filing the completed application. At least fifteen (15) days before the hearing, notice of such hearing shall be mailed to the following:

- (A) the applicant;
- (B) any regional council affected by the application; and
- (C) all emergency medical, ambulance, and invalid coach service providers operating in the region for which the new or expanded emergency medical service is requested.

(3) The Office shall grant, modify or deny any application for a new or expanded emergency medical service not more than 45 days following the adjournment of the hearing held pursuant hereto.

(Effective December 15, 1983)

Sec. 19a-180-6. Case in support

All information or materials received by the Office pursuant to sections 19a-180-3 and 19a-180-5 of these regulations shall be treated by the Office as a substantially complete case in support of the application. The burden shall be on the applicant to prove the need for the new or expanded emergency medical service.

(Effective December 15, 1983)

Sec. 19a-180-7. Factors to be considered

In determining whether a need for a new or expanded emergency medical service has been demonstrated, the Office shall consider the following factors:

- (a) The population to be served by the proposed service;
- (b) The geographic area to be served by the proposed service;
- (c) The volume of calls for the previous 12 months within such areas;
- (d) The impact of the proposed service on existing services in the area;
- (e) The potential improvement in service in the area including cost effectiveness and response times;
- (f) The location of the proposed principal and branch places of business in relation to health facilities and other providers;
- (g) The need for special services, if applicable; and
- (h) The recommendation of the any applicable regional council.

(Effective December 15, 1983)

Sec. 19a-180-8. Application limitation

If the Office determines after the hearing that no need exists for a particular new or expanded emergency medical service, no application for the same or substantially similar service from the same applicant shall be considered for a period of one year, except upon a determination of extraordinary circumstances by the Office.

(Effective December 15, 1983)

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Sec. 19a-180-9. Authorization for new or expanded emergency medical services

Any applicant who is granted authorization for a new or expanded emergency medical service shall have a maximum of six (6) months in which to acquire the necessary resources, equipment, and other material to comply with the terms of the authorizations. If the applicant fails to do so, the authorization will automatically become null and void.

(Effective December 15, 1983)

Sec. 19a-180-10. Exclusion

(a) Nothing in these regulations shall be construed to interpret the implementation of mobile intensive care service by an existing provider of ambulance service as an expansion of service. However, the provision of mobile intensive care by a person not previously providing emergency care shall be considered a new service.

(b) Any sale of an existing ambulance service business shall be exempt from the requirements for authorization for a new or expanded emergency medical services provided that: (1) the purchaser only provides services, operates vehicles or establishes branch offices which were provided, operated and established by the seller or purchaser prior to the sale; (2) the entire ambulance service business is transferred by seller to a single purchaser and said seller terminates all participation whatsoever in ambulance service business; and (3) the purchaser has satisfied all other conditions of licensure prior to operation of the purchased ambulance service. Any subsequent expansion of services provided, vehicles operated or locations established by the purchaser or seller shall be considered a “new or expanded service” as defined by section 19a-180-1(b) hereof and shall be subject to the full need for service process.

(Effective December 15, 1983)

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Agency

Department of Public Health

Subject

Anatomical Gifts

Inclusive Sections

§§ 19a-279l-1—19a-279l-5

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Sec. 19a-279l-5.	Coordination agreements

Anatomical Gifts

Sec. 19a-279l-1. Definitions

As used in Sections 19a-279l-1 through 19a-279l-4 inclusive, the following terms mean as stated in Section 19a-279a of Connecticut General Statutes:

- (a) “Anatomical Gift”
- (b) “Decedent”
- (c) “Document of Gift”
- (d) “Donor”
- (e) “Hospital”
- (f) “Part”
- (g) “Person”
- (h) “Physician” or “Surgeon”
- (i) “Procurement Organization”
- (j) “State”
- (k) “Technician”

(Effective February 26, 1990)

Sec. 19a-279l-2. Documentation

(a) A person who is at least eighteen years of age may make, amend, revoke or refuse to make an anatomical gift in accordance with section 19a-279b of the Connecticut General Statutes.

(b) If there is no medical record of a patient’s intention regarding an anatomical gift and the patient is at or near the time of death, the hospital administrator or the administrator’s designee shall:

- (1) discuss with the patient or the patient’s authorized representative the making or refusal to make an anatomical gift;
- (2) request the making of such gift unless the gift is not suitable based on accepted medical standards;
- (3) enter into the patient’s medical record:
 - (A) name and affiliation of requester;
 - (B) name, response and relationship to patient of person to whom request was made.

(Effective February 26, 1990; Amended December 29, 2000)

Sec. 19a-279l-3. Notification and search

(a) Upon admission of a person who is at or near the time of death, the hospital shall make a reasonable search for a document of gift or other information identifying the bearer as a donor or as a person who has refused to make an anatomical gift, unless such information is otherwise immediately available.

(b) The hospital shall notify the named donee if one is named and known to the hospital; if not, it shall notify an appropriate procurement organization and cooperate in

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implementation of the anatomical gift or release and removal of a part if the hospital knows that:

(1) any member of an authorized class of persons has made an anatomical gift of all or part of the body of a person pursuant to section 19a-279c of the Connecticut General Statutes:

(A) The order of priority of the authorized classes is:

- (i) spouse;
- (ii) adult son or daughter;
- (iii) either parent;
- (iv) adult brother or sister;
- (v) grandparent;
- (vi) guardian of the person;
- (vii) any person legally authorized to make health care decisions for the decedent prior to death, including but not limited to a health care agent;
- (viii) conservator of the person.

(B) An anatomical gift may be made by a person listed in subparagraph (A) above only if:

- (i) a person in a prior class is not available; and
- (ii) the person proposing the gift does not know of any contrary indications by the decedent, and
- (iii) the person proposing the gift does not know of any objection by a member of that person's class or a prior class.

(2) release or removal of a body part has been permitted under the auspices of the Chief Medical Examiner serving as facilitator for tissue harvesting and organ procurement, or

(3) a person in transit to the hospital is such a donor.

(c) An emergency medical services provider, as defined in section 19a-179-1 (g) of the Regulations of Connecticut State Agencies, finding a person who the emergency medical services provider believes to be dead or near death shall conduct a reasonable search for a document of gift or other information identifying the bearer as a donor or as a person who has refused to make an anatomical gift. The searcher shall send or cause to be sent to the hospital any document or other evidence relating to the making of an anatomical gift.

(Effective February 26, 1990; Amended December 29, 2000)

Sec. 19a-279l-4. Record keeping

(a) The document of gift, or a copy, may be deposited in any hospital.

(b) The medical records department shall establish a policy/procedure to release either appropriate information regarding the document of gift or the document of gift itself to a designated donee.

(c) The hospital shall maintain a system to ensure that if a document of gift is deposited, it will be retained in the medical records department and available, as the original or a copy

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thereof, to any designated donee.

(Effective February 26, 1990)

Sec. 19a-279l-5. Coordination agreements

Agreements or affiliations for coordination of procurement and use of human bodies and parts shall be in writing. A copy shall be maintained by each party to the agreement, and made available to the Department of Health Services on request.

(Effective February 26, 1990)

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Subject

Standards for Asbestos Abatement

Inclusive Sections

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Standards for Asbestos Abatement

Sec. 19a-332a-1. Definitions

The following definitions shall apply for the purpose of Section 19a-332a-1 to Section 19a-332a-16 inclusive.

(a) “Adequately wetted” means sufficiently mixed or coated with water, amended water or an aqueous solution; or the use of a removal encapsulant to prevent dust emissions;

(b) “Amended Water” means water to which a chemical wetting agent or removal encapsulant has been added to improve penetration;

(c) “Asbestos” means the asbestiform varieties of actinolite, amosite, anthophyllite, chrysotile, crocidolite and tremolite;

(d) “Asbestos Abatement” means the removal, encapsulation, enclosure, renovation, repair, demolition or other disturbance of asbestos-containing materials, but does not include activities which are related to (A) the removal or repair of asbestos cement pipe and are performed by employees of a water company as defined in Section 25-32a of the Connecticut General Statutes or (B) the removal of nonfriable asbestos-containing material found exterior to a building or structure other than material defined as regulated asbestos-containing material in 40 CFR 61, the national emission standards for hazardous air pollutants, as amended from time to time;

(e) “Asbestos Abatement Project” means any asbestos abatement performed within a facility involving more than three (3) linear feet or three (3) square feet of asbestos-containing material;

(f) “Asbestos Abatement Worker” means any employee of a licensed asbestos contractor who engages in asbestos abatement, has completed a training program approved by the department and has been issued a certificate by the department;

(g) “Asbestos Abatement Site Supervisor” means any employee of a licensed asbestos contractor who has been specifically trained as a supervisor in a training program approved by the department and who has been issued a certificate by the department;

(h) “Asbestos-Containing Material” (ACM) means material composed of asbestos of any type and in an amount greater than one percent by weight, either alone or mixed with other fibrous or nonfibrous material;

(i) “Asbestos Contractor” means any person engaged in asbestos abatement whose employees actually perform the asbestos abatement work and who has been issued a license by the commissioner;

(j) “Authorized Asbestos Disposal Facility” means a location approved for handling and disposing of asbestos waste by the Connecticut Department of Environmental Protection or by an equivalent regulatory agency if the material is disposed of outside the State of Connecticut;

(k) “Commissioner” means the Commissioner of Public Health or his/her authorized agent;

(l) “Conn OSHA” means the Connecticut Department of Labor, Occupational Safety and Health Division;

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(m) “Demolition” means the wrecking or taking out of any load-supporting structural member of a facility together with any related handling operations or the intentional burning of any facility;

(n) “Department” means the Connecticut Department of Public Health;

(o) “DEP” means the Connecticut Department of Environmental Protection;

(p) “Emergency Asbestos Abatement Project” means an asbestos abatement project which was not planned but results from a sudden unexpected event. This includes operations required by non-routine failures of equipment;

(q) “Emergency Demolition” means a demolition operation ordered by an authorized state or local official, that if not immediately attended to presents a safety or public health hazard;

(r) “Encapsulation” means the treatment of asbestos-containing material with a material that surrounds or embeds asbestos fibers in an adhesive matrix to prevent the release of fibers as the encapsulant creates a membrane over the surface (bridging encapsulant) or penetrates the material and binds its components together (penetrating encapsulant);

(s) “EPA” means the United States Environmental Protection Agency;

(t) “Enclosure” means the construction of an air-tight, impermeable, permanent barrier around asbestos-containing material to control the release of fibers into the air;

(u) “Facility” means any private or public building or structure including but not limited to those used for institutional, residential (including single family homes), commercial or industrial purposes and vessels while ashore or in drydock;

(v) “Facility Owner” means the person or entity having title to the facility. For purposes of publicly owned property only, the Facility Owner shall be defined to be the chief executive officer of the federal, state or municipal agency which owns or controls the use of the facility;

(w) “Friable Asbestos-Containing Material” means any asbestos-containing material that hand pressure can crumble, pulverize, or reduce to powder when dry and non-friable asbestos-containing material that potentially can be broken, crumbled, pulverized or reduced to powder as a result of asbestos abatement;

(x) “Glove Bag” means a manufactured polyethylene bag type of enclosure with built-in gloves, such as is placed with an air-tight seal around asbestos- containing material and which permits the asbestos-containing material contained by the bag to be removed without releasing asbestos fibers to the atmosphere;

(y) “Individual” means any human being;

(z) “Non Friable Asbestos-Containing Material” means any asbestos-containing material that hand pressure can not crumble, pulverize or reduce to powder when dry;

(aa) “OSHA” means the Occupational Safety and Health Administration of the U.S. Department of Labor;

(bb) “Person” means any individual, corporation, partnership, firm, association, sole proprietorship, the State of Connecticut or any of its political subdivisions, or any other entity;

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(cc) “Removal” means the taking out or stripping of any asbestos-containing materials from surfaces or structural components of a facility;

(dd) “Renovation” means altering, in any way other than demolition, one or more structural components. Operations in which load-supporting structural members are taken out are excluded;

(ee) “Repair” means the restoration of damaged asbestos-containing material; including but not limited to the sealing, patching, enclosing or encapsulating of damaged asbestos-containing material to prevent fiber release;

(ff) “Spot Repair” means any asbestos abatement performed within a facility involving not more than three (3) linear feet or three (3) square feet of asbestos containing material;

(gg) “Structural Component” means any pipe, duct, boiler, tank, reactor, turbine, furnace or other component at or in a facility or any structural member of a facility;

(hh) “Structural Member” means any load-supporting member of a facility such as beams and load-supporting walls or any non-load supporting member, such as ceilings and non-load supporting walls;

(ii) “Visible Residue” means any debris or dust on surfaces in areas within the enclosed work area where asbestos abatement has taken place and which is visible to the unaided eye. All visible residue is assumed to contain asbestos;

(jj) “Work Area” means the specific area or location where the actual asbestos abatement work is being performed or such other areas of a facility which the Commissioner determines may be hazardous to public health as a result of such asbestos abatement.

(Effective December 27, 1990; Amended April 5, 2001; Amended March 8, 2004)

Sec. 19a-332a-2. General provision

(a) No person shall engage in asbestos abatement unless in compliance with Section 19a-332a-3 to Section 19a-332a-12 inclusive.

(b) The requirements of Section 19a-332a-3 to Section 19a-332a-12 inclusive, shall apply to each facility as defined by these regulations.

(Effective December 27, 1990)

Sec. 19a-332a-3. Notification requirements

(a) The asbestos abatement contractor, the facility owners or any person who will be conducting demolition activities shall notify the Commissioner before engaging in any asbestos abatement which involves more than ten (10) linear feet or more than twenty five (25) square feet of asbestos-containing material or before engaging in the demolition of any facility. If the notification is provided by the asbestos abatement contractor, a copy of the notification shall be simultaneously submitted to the facility owner. Notification shall be on forms prescribed by the Commissioner. Notification shall be postmarked or hand delivered at least ten (10) days before the start of asbestos abatement or demolition activities. In the case of emergency asbestos abatement or emergency demolition, notification shall be postmarked or hand delivered within one (1) working day after the start of asbestos

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abatement or demolition. A copy of the written order requiring demolition shall accompany the notification. This notification shall not relieve the asbestos contractor, facility owner or any person who will be conducting demolition activities of the responsibility for making written notification as may be required by any other municipality, agency of the State of Connecticut, or any agency of the federal government. Such additional federal requirements may include, but are not limited to, notification to the EPA under requirements of the Clean Air Act, the Toxic Substances Control Act, the Asbestos School Hazard Abatement Act, and the Asbestos Hazard Emergency Response Act.

(b) A single asbestos abatement notification may be provided to the Department for asbestos abatement which will cumulatively involve more than ten (10) linear or more than twenty-five (25) square feet of asbestos-containing material when a facility owner can provide an accurate estimate of the additive amounts of asbestos-containing material. Such notification may be provided for a period of time not to exceed one year.

(c) Asbestos abatement notification to the Commissioner shall, at a minimum, include the following:

- (1) The name, address and telephone number of the asbestos contractor;
- (2) The name, address and telephone number of the facility owner;
- (3) The exact location of the facility;
- (4) The nature of the asbestos abatement;
- (5) The type of asbestos abatement activity;
- (6) A description of the facility including the size, age and use of the facility;
- (7) The amount of asbestos-containing material to be removed, enclosed or encapsulated or contained in the facility or part thereof to be demolished;
- (8) The scheduled start and completion dates;
- (9) A description of work practices to be followed to comply with Section 19a-332a-5 to Section 19a-332a-12; and,
- (10) The name and the location of the authorized asbestos disposal facility where asbestos-containing materials will be deposited.

(d) A separate notification form shall be completed for each facility for which there is a proposed demolition.

(e) Demolition notification to the commissioner shall, at a minimum, include the following:

- (1) The name, address and telephone number of any person undertaking the demolition;
- (2) The name, address and telephone number of the facility owner;
- (3) The location and street address (including building number or name and floor or room number, if appropriate), and city of the facility being demolished;
- (4) A description of the facility including its size, age and use;
- (5) A statement of whether an inspection of the facility has been conducted by a licensed asbestos inspector or inspector/management planner;
- (6) The start and completion dates;
- (7) The name and the location of the disposal facility where demolition materials will

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be deposited; and,

(8) The name, address and phone number of the demolition waste hauler.

(Effective December 27, 1990; Amended March 8, 2004)

Sec. 19a-332a-4. Recordkeeping

(a) The asbestos contractor shall maintain records of all asbestos abatement projects which it performs and shall provide a complete copy of these records to the facility owner upon completion of the project. The asbestos contractor and facility owner shall retain the records for thirty (30) years following completion of the project. These records shall be available to the Department upon request.

(b) The asbestos contractor shall record the following information for each project.

(1) The location and description of the project and the estimated amount and type of asbestos involved in each project;

(2) The start and completion dates of the project;

(3) A summary of the procedures used to comply with Sections 19a-332a-5 to 19a-332a-12;

(4) The name and address of the authorized asbestos disposal facility and verification from the authorized asbestos disposal facility indicating the amount of asbestos received for disposal;

(5) The methodology and results of all air sampling conducted during the abatement process;

(6) A complete list of the names and social security numbers of asbestos abatement workers, asbestos abatement site supervisors and other agents involved in the asbestos abatement activity and working for the asbestos contractor on that project and individuals entering the enclosed work area;

(7) A log of control of access to the work area;

(8) All records for compliance with the requirements of OSHA, Conn OSHA, DEP and EPA regulations; and,

(9) Documentation to demonstrate compliance with the post abatement reoccupancy criteria established by Section 19a-332a-12.

(Effective December 27, 1990; Amended March 8, 2004)

Sec. 19a-332a-5. General requirements for asbestos abatement projects

(a) Signs shall be posted which meet the specifications set forth in 29 CFR 1926.1101(k)(7)(ii)(A) at all approaches to the work area. Signs shall be posted a sufficient distance from the work area to permit a person to read the sign and take precautionary measures to avoid exposure to asbestos.

(b) The facility heating, ventilating and air conditioning (HVAC) systems within the asbestos abatement work area shall be shut down, locked out and isolated to prevent contamination of and fiber dispersal to other areas of the facility.

(c) The work area shall be isolated from non-work areas by air-tight barriers attached

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securely in place. All openings between the work area and non-work areas including but not limited to windows, doorways, elevator openings, corridor entrances, ventilation openings, drains, ducts, grills, grates, diffusers and skylights, shall be sealed airtight with 6 mil polyethylene sheeting.

(d) All movable objects which can be removed from the work area shall be removed. Cleaning of contaminated items shall be performed if the item is to be salvaged or reused. Otherwise the item shall be properly disposed of as asbestos waste. All non-movable objects in the work area shall be covered with a minimum of 6 mil polyethylene sheeting secured in place.

(e) Floor and wall surfaces in the work area shall be covered with polyethylene sheeting or equivalent. All seams and joints shall be sealed with tape or equivalent. Floor covering shall consist of at least two layers of 6 mil polyethylene and must cover at least the bottom 12 inches of adjoining wall. Wall covering shall consist of a minimum of two layers of 4 mil polyethylene sheet which shall overlap the floor covering to prevent leaks. There shall be no seams in the polyethylene sheet at the wall-to-floor joints.

(f) Work area access shall be restricted to authorized personnel afforded proper respiratory protection and protective clothing.

(g) Clean-up procedures shall involve high efficiency particulate air (HEPA) filtration and wet cleaning techniques. Amended water shall be used. The sequence of wet cleaning and HEPA-filtered vacuuming shall be repeated until no visible residue is observed in the work area.

(h) Negative pressure ventilation units with HEPA filtration shall be provided in sufficient number to allow at least one (1) work place air change every 15 minutes. Filtered air should be exhausted to areas outside the building which are not near any intake for the building ventilation system.

(i) Waste water generated during asbestos abatement shall be filtered by best available technology prior to discharge.

(j) All asbestos containing waste shall be adequately wetted with an amended water solution and be placed in leak-tight containers.

(k) All leak-tight containers shall be labeled in accordance with OSHA 29 CFR 1910.1200 and EPA 40 CFR Part 61.152 as appropriate.

(l) Disposal of asbestos waste shall be at an authorized asbestos disposal facility. If the authorized asbestos disposal site is located within Connecticut, written authorization for disposal shall be obtained from the Department of Environmental Protection, Bureau of Waste Management.

(Effective December 27, 1990; Amended March 8, 2004)

Sec. 19a-332a-6. Worker decontamination system for asbestos abatement projects

(a) At all asbestos abatement projects, work areas shall be equipped with decontamination facilities consisting of: a clean room, a shower room, and an equipment room. Each room shall be separated from the other and from the work area by airlocks such

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as will prevent the free passage of air or asbestos fibers and shall be accessible through doorways protected with two (2) overlapping 4 mil polyethylene sheets. The clean room (or change room) shall be equipped with suitable hooks, lockers, shelves, etc. for workers to store personal articles and clothing. The shower room shall be contiguous to the clean room and equipment room. All personnel entering or leaving the work area shall pass through the shower room. The number of showers provided shall satisfy the requirements of OSHA 29 CFR 1910.141 (d) (3) (ii). Warm water shall be supplied to the showers. The equipment room (dirty room) shall be situated between the shower room and the work area, and separated from both by means of suitable barriers or overlapping flaps such as will prevent the free passage of air or asbestos fibers.

(b) No person or equipment shall leave the asbestos abatement project work area unless first decontaminated by showering, wet washing or HEPA vacuuming to remove all asbestos debris. No asbestos contaminated materials or persons shall enter the clean room.

(c) Where feasible, decontamination systems shall abut the work area. In situations where it is not possible, due to unusual conditions, to establish decontamination systems contiguous to the work area, personnel shall be directed to remove visible asbestos debris from their persons by HEPA-filtered vacuuming prior to donning clean disposable coveralls while still in the work area, and proceeding directly to a remote decontamination system to shower and change clothes.

(d) In specific situations where the asbestos contractor determines that it is not feasible to establish a contiguous decontamination system at a work site, the asbestos contractor shall provide written notification and provide a copy to the facility owner of intent to utilize a remote decontamination system. Such systems must be operated in conformance with 29 CFR 1926.1101(j). Such notice shall be made with the notification required under Section 19a-332a-3.

(Effective December 27, 1990; Amended March 8, 2004)

Sec. 19a-332a-7. Specific requirements for asbestos removal

(a) All ACM to be removed or disturbed by removal shall be adequately wetted unless otherwise approved by the Department.

(b) Components shall be removed intact or in large sections whenever possible and carefully lowered to the floor.

(c) A coating of encapsulant, chosen so as to be compatible with subsequent coverings, shall be applied to all surfaces that have been stripped of ACM to securely seal any residual fibers that may be present after the surfaces have been visually inspected and found to be free of all visible residue.

(d) No equipment, supplies, or materials (except properly containerized waste material) shall be removed from an asbestos abatement project work area unless such equipment, supplies, or materials have been thoroughly decontaminated and cleaned free of asbestos debris. Where the configuration of the equipment, supplies or materials is such that decontamination and cleaning free of asbestos debris is neither possible nor feasible, then

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the object shall be thoroughly wrapped in a minimum of two (2) layers of six (6) mil polyethylene sheeting with all joints, seams and overlaps sealed with tape; or containerized in a metal drum with a locking lid. Examples include, but are not limited to, air filtration or HEPA-filtered vacuuming equipment which may be wrapped in polyethylene rather than dismantling beyond the HEPA filters for cleaning purposes; sections of insulated pipe or other objects to be disposed of intact may be wrapped in polyethylene without prior removal of asbestos. Wood or other materials used to construct on-site decontamination or shower units may be wrapped in polyethylene for disposal or transport to another contaminated work site for re-use.

(e) HEPA-filtered vacuum cleaners shall be emptied of collected asbestos waste contents prior to removal of the equipment from the work area.

(f) All pre-filters in the air filtration devices shall be removed prior to removal of the unit from an asbestos work site. The air filtration device shall be damp cleaned completely inside and out. The equipment shall be wrapped in polyethylene pursuant to Subsection 19a-332a-7 (b) prior to removing it from the work area. The replacement of filters shall occur prior to the beginning of the next asbestos abatement project after installation of containment barriers.

(Effective December 27, 1990)

Sec. 19a-332a-8. Specific requirements for asbestos encapsulation

(a) All loose and hanging ACM shall be adequately wetted and removed as required in Section 19a-332a-7.

(b) Filler material applied to gaps in existing material shall contain no asbestos, adhere well to the substrate and provide an adequate base for the encapsulant.

(c) Encapsulants shall be applied using only airless spray equipment unless otherwise approved by the Department.

(Effective December 27, 1990)

Sec. 19a-332a-9. Specific requirements for asbestos enclosure

(a) All loose and hanging ACM shall be adequately wetted and removed as required in Section 19a-332a-7 unless otherwise approved by the Department.

(b) Areas of ACM shall be sprayed with an encapsulant if they are to be disturbed during the installation of hangers, brackets or other portions of the enclosure.

(c) Non-asbestos containing substitutes shall be used to patch surfacing materials or thermal system insulation.

(Effective December 27, 1990)

Sec. 19a-332a-10. Specific requirements for spot repairs

(a) Air-tight barriers shall be constructed to assure that asbestos fibers released during abatement activities are contained within the work area. Glove bags are permitted for removal or repair of asbestos-containing materials.

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(b) All asbestos-containing materials shall be wet and placed in leak tight containers prior to being disturbed. They shall be kept wet until containerized.

(c) A HEPA-filtered vacuum cleaner or wet cleaning technique shall be used to clean up the work area following abatement until there is no visible residue.

(d) Asbestos-containing waste shall be properly containerized in appropriately labeled impermeable and leak tight containers prior to disposal.

(e) All leak tight containers shall be labeled in accordance with OSHA 29 CFR 1926.1101(k)(8) and EPA 40 CFR part 61.152 as appropriate.

(f) Waste water generated during asbestos abatement shall be filtered by best available technology prior to discharge.

(g) Disposal of asbestos waste shall be at an authorized asbestos disposal facility. If the authorized asbestos disposal site is located within Connecticut, written authorization for disposal shall be obtained from the Department of Environmental Protection, Bureau of Waste Management.

(Effective December 27, 1990; Amended March 8, 2004)

Sec. 19a-332a-11. Alternative work practices

The Department may approve an alternative procedure for an asbestos abatement project or spot repair. The alternative procedures shall be submitted in writing and in advance for review by the Department and shall provide equivalent or a greater measure of asbestos emission control than the work practices prescribed by these regulations. Such approval may be granted for a period of time, not to exceed one year, for specified similar asbestos abatement projects or spot repairs performed within a facility. Such approval may be given for specified kinds of facilities or for asbestos abatement projects or spot repairs which utilize similar work procedures.

(Effective August 5, 1988)

Sec. 19a-332a-12. Post abatement reoccupancy criteria for asbestos abatement projects for friable asbestos-containing material

(a) No individual shall reoccupy the work area of an asbestos abatement project within a facility until compliance with the reoccupancy requirements of this section is achieved.

(b) Except as required by EPA Regulation 40 CFR Part 763 which applies to public and private schools, an asbestos abatement project shall be considered complete when there is no visible residue in the work area and when air samples demonstrate that the ambient interior airborne concentration of asbestos after the abatement project, does not exceed the levels specified in Subsection 19a-332a-12 (e).

(c) Air samples shall be collected using aggressive sampling as described in Appendix A of 40 CFR Part 763, subpart E to monitor air for post abatement reoccupancy after each asbestos abatement project.

(d) Air samples collected under this Section shall be analyzed for asbestos using laboratories accredited by the National Institute of Standards and Technology to conduct

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such analysis using transmission electron microscopy (TEM) or:

Under circumstances specified in this section, laboratories accredited by the American Industrial Hygiene Association Proficiency Analytical Testing Program for phase contrast microscopy (PCM); or individuals listed in the American Industrial Hygiene Association's Asbestos Analyst's Registry, or until the National Institute of Standards and Technology TEM laboratory accreditation program is operational, laboratories that use the protocol described in Appendix A of 40 CFR Part 763, Subpart E.

(e) Except as provided for in Subsections 19a-332a-12 (f), and 19a-332a-12 (g), an asbestos abatement project shall be considered complete when the average concentration of asbestos of five air samples collected within the work area and analyzed by the TEM method in Appendix A of 40 CFR Part 763 subpart E, is not statistically significantly different, as determined by the Z-test calculation found in Appendix A of 40 CFR Part 763, subpart E, from the average asbestos concentration of five air samples collected at the same time outside the work area and analyzed in the same manner, and the average asbestos concentration of the three field blanks described in Appendix A of 40 CFR Part 763, subpart E, is below the filter background level, as defined in Appendix A of 40 CFR Part 763 subpart E, of 70 structures per square millimeter (70 s/mm²).

(f) An asbestos abatement project may also be considered complete if the volume of air drawn for each of the five samples collected within the work area is equal to or greater than 1,199 L. of air for a 25 mm. filter or equal to or greater than 2,799 L. of air for a 37 mm. filter, and the average concentration of asbestos as analyzed by the TEM method in Appendix A, of 40 CFR part 763 subpart E. For the five air samples does not exceed the filter background level, as defined in Appendix A, of 70 structures per square millimeter (70 s/mm²). If the average concentration of asbestos of the five air samples within the work area exceeds 70 s/mm², or if the volume of air in each of the samples is less than 1,199 L. of air for a 25 mm. filter or less than 2,799 L. of air for a 37 mm. filter, the project shall be considered complete only when the requirements of subsections 19a-332a-12 (e) and 19a-332a-12 (g) are met.

(g) Air samples for post abatement reoccupancy may be collected and analyzed by phase contrast microscopy (PCM) to confirm completion of an asbestos abatement project involving less than or equal to 1500 square feet or 500 linear feet of asbestos-containing material. The project shall be considered complete when the results of samples collected in the work area and analyzed by phase contrast microscopy using the most current National Institute for Occupational Safety and Health (NIOSH) method 7400, to show that the concentration of fibers for each of the five samples is less than or equal to a limit of quantitation for PCM (0.010 fibers per cubic centimeter (0.010 f/cm³) of air).

(Effective December 27, 1990)

Sec. 19a-332a-13. Repealed

Repealed December 27, 1990.

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Sec. 19a-332a-14. Inspection of asbestos abatement projects

(a) The Commissioner or authorized agent shall, after proper identification, have the right to enter into any facility, or onto any property where asbestos abatement is planned or is being performed or has been performed in order to determine whether such asbestos abatement is being performed in a manner consistent with good safe practices and in accordance with these regulations.

(b) Entry into the facility or onto the property where asbestos abatement is being planned or performed shall be at reasonable times.

(Effective August 5, 1988)

Sec. 19a-332a-15. Order to cease activity

(a) Whenever the Commissioner has reason to believe on the basis of inspections or tests that asbestos abatement is being performed in violation of these regulations or, in the judgment of the Commissioner, is endangering the public's health, the Commissioner may issue a written or printed cease activity order to any person who performs, supervises or controls such asbestos abatement. Such order shall specifically describe the nature of the violation or condition endangering the public's health.

(b) After receipt of a cease activity order, no person shall conduct asbestos abatement except in accordance with the provisions of the order.

(c) Compliance with the provisions of a cease activity order shall be determined by the Commissioner on the basis of re-inspection or additional tests as deemed necessary by the Commissioner.

(d) Within seven (7) business days of receipt of a written request of the person subject to a cease activity order, the Commissioner shall hold a hearing to provide the person subject to the order an opportunity to be heard and show that asbestos abatement is being performed in accordance with these regulations and/or without endangering the public health. The cease activity order shall remain in effect until seven days after said hearing, within which time the Commissioner shall determine whether said order should continue in effect. The cease activity order shall be revoked at the end of said seven day period if no decision is made by the Commissioner or if so ordered by the Commissioner.

(Effective December 27, 1990)

Sec. 19a-332a-16. Application by the attorney general to the court

Whenever, in the judgment of the Commissioner, any person has engaged in or is about to engage in any acts or practices which constitute or will constitute a violation of these regulations, the Commissioner may request the Attorney General to make application to a court of appropriate jurisdiction for an order enjoining such acts or practices or for an order directing compliance with these regulations.

(Effective August 5, 1988)

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Department of Public Health

**Licensure and Training Requirements for Persons Engaged in Asbestos Abatement
and Asbestos Consultation Services**

Sec. 19a-332a-17—19a-332a-21. Transferred

Transferred to Sec. 20-440-1—20-440-5., June 4, 1999

Sec. 19a-332a-22. Transferred

Transferred to Sec. 20-440-7., June 4, 1999

Sec. 19a-332a-23. Transferred

Transferred to Sec. 20-440-9., June 4, 1999

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**Licensure and Training Requirements for Persons Engaged in Asbestos Abatement
and Consultation Services**

Inclusive Sections

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Sec. 19a-332e-2.	Assessment of civil penalties

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Licensure and Training Requirements for Persons Engaged in Asbestos Abatement and Consultation Services

Sec. 19a-332e-1. Definitions. As used in sections 19a-332e-1 through 19a-332e-2 of the Regulations of Connecticut State Agencies

(1) “Asbestos-containing material” or “ACM” means material composed of asbestos of any type and in an amount greater than one percent by weight, either alone or mixed with other fibrous or nonfibrous material.

(2) “Commissioner” means the commissioner of the Department of Public Health.

(3) “Department” means the Department of Public Health.

(4) “Local Education Agency” or “LEA” means:

(A) Any local educational agency as defined in Section 198 of the Elementary and Secondary Education Act of 1965, 20 USC 3381, as amended from time to time;

(B) the owner of any nonpublic, nonprofit elementary, or secondary school building; or

(C) the governing authority of any school operated under the defense dependents’ education system provided for under the Defense Dependents’ Education Act of 1978, 20 USC 921, et seq., as amended from time to time.

(5) “Person” means any individual, corporation, partnership, firm, association, sole proprietorship, the State of Connecticut or any of its political subdivisions, or any other entity except an LEA as defined in subsection (4) of this section.

(Adopted effective June 4, 1999)

Sec. 19a-332e-2. Assessment of civil penalties

(a) **Establishment of civil penalty.** In setting a civil penalty in a particular case the commissioner shall consider all factors which he deems relevant, including but not limited to those listed in subsection (b) of section 19a-332e of the Connecticut General Statutes.

(b) **Explanation of assessment.** When the commissioner imposes a civil penalty under subsection (a) of section 19a-332e of the Connecticut General Statutes, the commissioner shall provide a written explanation of the methodology employed and a written summary of calculations used to determine a particular assessment upon written request by the affected person.

(c) **Calculation of assessment.** The total penalty assessed shall be calculated by adding all the applicable penalties specified in section 19a-332e-2(a) of the Regulations of Connecticut State Agencies.

(d) **Record of mitigation.** The department shall maintain a written record of each instance in which the commissioner mitigates a civil penalty pursuant to subsections (b) and (e) of Section 19a-332e of the Connecticut General Statutes. The record shall include the name and address of the person, the violation(s), the amount of the civil penalty before and after mitigation, and the reasons for mitigation.

(d) **Schedules of penalties.**

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		LEA	Other Person
Section 19a-333a-2	General Local Education Responsibilities	\$50–\$5000	X
Section 19a-333a-3	Inspections and Reinspections	\$50–\$5000	\$50–\$25000
Section 19a-333a-4	Sampling	\$50–\$1000	\$50–\$2000
Section 19a-333a-5	Analysis	\$50–\$1000	\$50–\$1000
Section 19a-333a-6	Assessment	\$50–\$1000	\$50–\$1000
Section 19a-333a-7	Response Action	\$50–\$5000	\$50–\$25000
Section 19a-333a-8	Operations and Maintenance	\$50–\$1000	\$50–\$1000
Section 19a-333a-9	Training and Periodic Surveillance	\$50–\$2500	\$100–\$10000
Section 19a-333a-10	Management Plans	\$50–\$5000	\$50–\$25000
Section 19a-333a-11	Recordkeeping	\$50–\$1000	\$50–\$2000
Section 19a-333a-12	Warning Labels	\$50–\$1000	\$50–\$1000
Section 19a-333a-13	Exclusions	\$50–\$5000	\$50–\$25000

TABLE B
Standards for Asbestos Abatement

		LEA	Other Person
Section 19a-332a-3	Notification of Asbestos Abatement	\$50–\$1000	\$50–\$2000
Section 19a-332a-4	Recordkeeping	\$50–\$1000	\$50–\$2000
Section 19a-332a-5	General Requirements for Asbestos Abatement Projects	\$50–\$5000	\$50–\$25000
Section 19a-332a-6	Worker Decontamination System for Asbestos Abatement Projects	\$100–\$2500	\$100–\$10000
Section 19a-332a-7	Specific Requirements for Asbestos Removal	\$50–\$1000	\$50–\$2000
Section 19a-332a-8	Specific Requirements for Encapsulation	\$50–\$1000	\$50–\$2000
Section 19a-332a-9	Specific Requirements for Enclosure	\$50–\$1000	\$50–\$2000
Section 19a-332a-10	Specific Requirements for Spot	\$50–\$1000	\$50–\$2000

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	Repairs		
Section 19a-332a-11	Alternative Work Practices	\$50–\$5000	\$50–\$25000
Section 19a-332a-12	Post Abatement Reoccupancy Criteria for Asbestos Abatement Projects for Friable Asbestos-Containing Material	\$50–\$5000	\$50–\$25000
Section 19a-332a-14	Inspection for Asbestos Abatement Projects	\$500–\$5000	\$1000–\$25000
Section 19a-332a-15	Order to Cease Activity	\$500–\$5000	\$1000–\$25000

TABLE C

Licensure and Training Requirements for Persons Engaged in Asbestos Abatement and Consultation Services

		LEA	Other Person
Section 20-440-2	Licensure of Asbestos Contractors	\$100–\$2500	\$100–\$10000
Section 20-440-3	Licensure of Asbestos Consultants	\$100–\$2500	\$100–\$10000
Section 20-440-4	Application for Licensure and Certification as an Asbestos Consultant	\$100–\$2500	\$100–\$10000
Section 20-440-5	Certification and Employment as an Asbestos Abatement Site Supervisor or as an Asbestos Abatement Worker	\$100–\$2500	\$100–\$10000
Section 20-440-7	Training Requirements	\$100–\$2500	\$100–\$10000
Section 20-440-8	Training Provider Administrative Tasks and Certification Requirements	\$50–\$1000	\$50–\$2000
Section 20-440-9	Recordkeeping	\$50–\$1000	\$50–\$2000
Section 20-441	Refresher Training	\$50–\$1000	\$50–\$2000

(Adopted effective June 4, 1999)

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Asbestos-Containing Materials in Schools

Inclusive Sections

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Sec. 19a-333-10.	Management plans
Sec. 19a-333-11.	Recordkeeping
Sec. 19a-333-12.	Warning labels
Sec. 19a-333-13.	Exclusions

Asbestos-Containing Materials in Schools

Sec. 19a-333-1. Definitions, as used in sections 19a-333-1 through 19a-333-13

(a) “Act” means the federal Toxic Substances Control Act (TSCA), 15 U.S.C. sections 2601 et seq. as amended;

(b) “Accessible” when referring to ACM, means that the material is subject to disturbance by school building occupants or custodial or maintenance personnel in the course of their activities;

(c) “Accredited” or “accreditation” when referring to a person or laboratory, means that such person or laboratory is accredited in accordance with section 206 of Title II of the Act and with the requirements established by sections 19a-332-17 through 19a-332-23 of the regulations of Connecticut State Agencies as amended;

(d) “Air erosion” means the passage of air over friable ACBM which may result in the release of asbestos fibers;

(e) “Approved Training Provider” means any individual or entity which satisfactorily demonstrates through application and submission of course agenda, faculty resumes, training manuals, examination materials, and equipment inventory that it meets the requirements established by section 19a-332-17 through section 19a-332-23 of the regulations of Connecticut State Agencies as amended;

(f) “Asbestos” means the asbestiform varieties of: chrysotile (serpentine), crocidolite (riebeckite), amosite (cummingtonitegrunerite), anthophyllite, tremolite, and actinolite;

(g) “Asbestos-containing material” (ACM) when referring to school buildings, means any material or product which contains more than 1 percent asbestos by weight either alone or mixed with other fibrous or nonfibrous material;

(h) “Asbestos-containing building material” (ACBM) means surfacing ACM, thermal system insulation ACM, or miscellaneous ACM that is found in or on interior structural members or other parts of a school building;

(i) “Asbestos contractor” means any accredited person or entity engaged in asbestos abatement whose employees actually perform the asbestos abatement work;

(j) “Asbestos debris” means pieces of ACBM that can be identified by color, texture, or composition, including dust if the dust is determined by an accredited inspector to be ACM;

(k) “Asbestos inspector” means any accredited person who identifies, assesses the condition of, or collects bulk samples of suspected ACM;

(l) “Asbestos management planner” means a person who is accredited to assess the health hazard posed by the asbestos-containing material, determines the appropriate response action, and develops a schedule for implementing response actions in schools;

(m) “Asbestos project designer” means any accredited person who determines how asbestos abatement work should be conducted and who prepares, for purposes of an abatement project, plans, designs, procedures, workscope or other substantive directions or criteria;

(n) “Assessment” when used in reference to ACBM in a school building, means any evaluation of ACBM, or suspected ACBM, which leads to a determination of the need for

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response action;

(o) “Commissioner” means the Commissioner of Health Services or his/her authorized agent;

(p) “Damaged friable miscellaneous ACM” means friable miscellaneous ACM which has deteriorated or sustained physical injury such that the internal structure (cohesion) of the material is diminished or, if applicable, which has delaminated such that its bond to the substrate (adhesion) is diminished or which, for any other reason, lacks fiber cohesion or adhesion qualities. Such damage or deterioration may be illustrated by the separation of ACM into layers; separation of ACM from the substrate; flaking, blistering, or crumbling of the ACM from the substrate; significant or repeated water stains, scrapes, gouges, marks, asbestos debris originating from the ACBM in question, or other signs of physical injury on the ACM;

(q) “Damaged friable surfacing ACM” means friable surfacing ACM which has deteriorated or sustained physical injury such that the internal structure (cohesion) of the material is diminished or which has delaminated such that its bond to the substrate (adhesion) is diminished or which, for any other reason, lacks fiber cohesion or adhesion qualities as illustrated by the separation of ACM into layers; separation of ACM from the substrate; flaking, blistering, or crumbling of the ACM surface; water damage; significant or repeated water stains, scrapes, gouges, marks, asbestos debris originating from the ACBM in question, or other signs of physical injury on the ACM;

(r) “Damaged or significantly damaged thermal system insulation ACM” means thermal system insulation ACM on pipes, boilers, tanks, ducts, and other thermal system insulation equipment where the insulation has lost its structural integrity, or its covering, in whole or in part, is crushed, waterstained, gouged, punctured, missing, or not intact such that it is not able to contain fibers, as may be further illustrated by occasional punctures, gouges, or other signs of physical injury to ACM; occasional water damage on the protective coverings/jackets; or exposed ACM ends or joints, or asbestos debris originating from the ACBM in question;

(s) “Department” means the Connecticut Department of Health Services;

(t) “Encapsulation” means the treatment of ACBM with a material that surrounds or embeds asbestos fibers in an adhesive matrix to prevent the release of fibers, as the encapsulant creates a membrane over the surface (bridging encapsulant) or penetrates the material and binds its components together (penetrating encapsulant);

(u) “Enclosure” means an airtight, impermeable, permanent barrier around ACBM to prevent the release of asbestos fibers into the air;

(v) “EPA” means the United States Environmental Protection Agency;

(w) “Fiber release episode” means any uncontrolled or unintentional disturbance of ACM resulting in visible emission;

(x) “Friable” means that the material, when dry, may be crumbled, pulverized, or reduced to powder by hand pressure, and includes previously nonfriable material after it becomes damaged to the extent that when dry it may be crumbled, pulverized, or reduced to powder

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by hand pressure;

(y) “Functional space” means a room, group of rooms, or areas of similar usage (including crawl spaces or the space between a dropped ceiling of the floor of roof deck above), such as classroom(s), a cafeteria, gymnasium, hallway(s), designated by a person accredited to prepare management plans, design abatement projects, or conduct response actions;

(z) “High-efficiency particulate air” (HEPA) means a filtering system capable of trapping and retaining at least 99.97 percent of all monodispersed particles 0.3 micrometer in diameter or larger;

(aa) “Homogeneous area” means an area of surfacing material, thermal system insulation material, or miscellaneous material that is uniform in color and texture;

(bb) “Local education agency” means:

(1) any local educational agency as defined in Section 198 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. section 3381) as amended; or

(2) the owner of any nonpublic, nonprofit elementary, or secondary school building; or

(3) the governing authority of any school operated under the defense dependents education system provided for under the Defense Dependents’ Education Act of 1978 (20 U.S.C. sections 921, et seq.) as amended;

(cc) “Miscellaneous ACM” means miscellaneous material that is ACM in a school building;

(dd) “Miscellaneous material” means interior building material on structural components, structural members or fixtures, such as floor and ceiling tiles, and does not include surfacing material or thermal system insulation;

(ee) “Moveable object” means a piece of equipment, a fixture or furniture in the work area which can be readily removed from the work area;

(ff) “Nonfriable” means material in a school building which when dry may not be crumbled, pulverized, or reduced to powder by hand pressure;

(gg) “Operations and maintenance program” (O & M) means a program of work practices to maintain friable ACM in good condition, ensure cleanup of asbestos fibers previously released, and prevent further release by minimizing and controlling friable ACM disturbance or damage;

(hh) “OSHA” means the Occupational Health and Safety Administration of the United States Department of Labor;

(ii) “Potential damage” means circumstances in which:

(1) friable ACM is in an area regularly used by building occupants, including maintenance personnel, in the course of their normal activities, and

(2) there are indications that the material or its covering will become damaged, deteriorated, or delaminated due to factors such as changes in building use, changes in operations and maintenance practices, changes in occupancy, or recurrent damage;

(jj) “Potential significant damage” means circumstances in which:

(1) friable ACM is in an area regularly used by building occupants, including

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maintenance personnel, in the course of their normal activities, and

(2) there are indications that the material or its covering will become significantly damaged, deteriorated, or delaminated due to factors such as changes in building use, changes in operations and maintenance practices, changes in occupancy, or recurrent damage or the material is subject to major or continuing disturbance, due to factors including, but not limited to, accessibility or, under certain circumstances, vibration or air erosions;

(kk) “Preventive measures” means actions taken to reduce disturbance of ACBM or otherwise eliminate the reasonable likelihood of the materials becoming damaged or significantly damaged;

(ll) “Removal” means the taking out or the stripping of substantially all ACBM from a damaged area, a functional space, or a homogeneous area in a school building;

(mm) “Repair” means restoration of damaged ACBM to an undamaged condition or to an intact state so as to prevent fiber release, including but not limited to the sealing, patching, enclosing or encapsulating of damaged asbestos-containing material to prevent fiber release;

(nn) “Response action” means a method, including removal, encapsulation, enclosure, repair, operations and maintenance, that protects human health and the environment from friable ACBM;

(oo) “Routine maintenance area” means an area, such as a boiler room or mechanical room, that is not normally frequented by students and in which maintenance employees or contract workers regularly conduct maintenance activities;

(pp) “Sampling area” means any area, within a school building which contains friable material that is homogeneous in texture and appearance;

(qq) “School” means any elementary or secondary school as defined in Section 198 of the Elementary and Secondary Education Act of 1965 (20 U.S.C. section 2854) as amended;

(rr) “School building” means:

(1) any structure suitable for use as a classroom, including a school facility such as a laboratory, library, school eating facility, or facility used for the preparation of food;

(2) any gymnasium or other facility which is specially designed for athletic or recreational activities for an academic course in physical education;

(3) any other facility used for the instruction or housing of students or for the administration of educational or research programs;

(4) any maintenance, storage, or utility facility, including any hallway, essential to the operation of any facility described in this definition of “school building” under paragraphs (1), (2), or (3);

(5) any portico or covered exterior hallway or walkway, or

(6) any exterior portion of a mechanical system used to condition interior space;

(ss) “Significantly damaged friable miscellaneous ACM” means damaged friable surfacing ACM in a functional space where the damage is extensive and severe;

(tt) “State” means the State of Connecticut;

(uu) “Surfacing ACM” means surfacing material that is ACM;

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(vv) “Surfacing material” means material in a school building that is sprayed-on, troweled-on, or otherwise applied to surfaces, such as acoustical plaster on ceilings and fireproofing materials on structural members, or other materials on surfaces for acoustical, fireproofing, or other purposes;

(ww) “Suspect ACBM” means building material including thermal system insulation, surfacing material or miscellaneous material that is found in or on interior structural members or other parts of a school building and is determined or assumed by an accredited inspector to be ACM;

(xx) “Thermal system insulation” means material in a school building applied to pipes, fittings, boilers, breeching, tanks, ducts, or other interior structural components to prevent heat loss or gain, or water condensation, or for other purposes;

(yy) “Thermal system insulation ACM” means thermal system insulation that is ACM;

(zz) “Vibration” means the periodic motion of friable ACBM which may result in the release of asbestos fibers.

(Effective December 1, 1992)

Sec. 19a-333-2. General local education agency responsibilities

Each local education agency shall:

(a) ensure that the activities of any persons who perform inspections, reinspections, and periodic surveillance, develop and update management plans, and develop and implement response actions, including operations and maintenance, are carried out in accordance with the requirements of sections 19a-333-1 through 19a-333-13 of the regulations of Connecticut State Agencies;

(b) ensure that all custodial and maintenance employees are properly trained as required by sections 19a-333-1 through 19a-333-13 of the regulations of Connecticut State Agencies and other applicable federal and/or state regulations (e.g., the OSHA asbestos standard for construction or applicable state regulations);

(c) ensure that workers and building occupants, or their legal guardians, are informed at least once each school year about inspections, response actions, and post-response action activities, including periodic reinspections and surveillance activities that are planned or in progress;

(d) ensure that short-term workers (e.g., telephone repair workers, utility workers, or exterminators) who may come in contact with asbestos in a school are provided information regarding the locations of ACBM and suspected ACBM assumed to be ACM;

(e) ensure that warning labels are posted in accordance with section 19a-333-12 of the regulations of Connecticut State Agencies;

(f) ensure that management plans are available for inspection and notification of such availability has been provided as specified in the management plan under subsection (f) of section 19a-333-10 of the regulations of Connecticut State Agencies;

(g) designate a person to ensure that requirements under this section are properly implemented;

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(h) ensure that the training of the person designated under subsection (g) of this section provides a basic knowledge of:

- (1) health effects of asbestos,
- (2) detection, identification, and assessment of ACM,
- (3) options for controlling ACBM,
- (4) asbestos management programs, and
- (5) relevant federal and state regulations concerning asbestos, including but not necessarily limited to those in sections 19a-333-1 through 19a-333-13 of the regulations of Connecticut State Agencies and those of the following federal agencies;

(A) Occupational Safety and Health Administration, (B) Department of Labor, (C) Department of Transportation and (D) Environmental Protection Agency;

(i) avoid any conflict of interest in the selection of accredited personnel to perform activities under sections 19a-333-1 through 19a-333-13 of the regulations of Connecticut State Agencies.

(Effective December 1, 1992)

Sec. 19a-333-3. Inspection and reinspections

(a) Inspection

(1) All local education agencies are required to inspect each school building that they lease, own or otherwise use as a school building to identify all locations of friable and nonfriable ACBM except for those buildings which have been inspected as required by the Act and for which documentation of said inspection was filed with the State as required by the Act. The inspection shall be conducted as described under subdivisions (2) and (3) of this subsection prior to use as a school building.

(2) Each inspection shall be made by an accredited inspector.

(3) For each area of a school building, except as excluded under section 19a-333-13 of the regulations of Connecticut State Agencies, each person performing an inspection shall:

- (A) visually inspect the area to identify the locations of all suspected ACBM;
- (B) touch all suspected ACBM to determine whether it is friable;
- (C) identify all homogeneous areas of friable suspected ACBM and all homogeneous areas of nonfriable suspected ACBM;

(D) for each identified homogeneous area that is not assumed to be ACM, collect and submit for analysis bulk samples under sections 19a-333-4 and 19a-333-5 of the regulations of Connecticut State Agencies;

(E) assess, under section 19a-333-6 of the regulations of Connecticut State Agencies, friable material in areas where samples are collected, friable material in areas that are assumed to be ACBM, and friable ACBM identified during a previous inspection;

(F) record the following and submit to the person designated under section 19a-333-2 of the regulations of Connecticut State Agencies, a copy of such record for inclusion in the management plan within thirty (30) days of the inspection:

- (i) an inspection report with the date of the inspection signed by each accredited person

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making the inspection, state of accreditation, and if applicable his or her accreditation number;

(ii) an inventory of the locations of the homogeneous areas where samples are collected, exact location where each bulk sample is collected, dates that samples are collected, homogeneous areas where friable suspected ACBM is assumed to be ACM, and homogeneous areas where nonfriable suspected ACBM is assumed to be ACM;

(iii) a description of the manner used to determine sampling locations, the name and signature of each accredited inspector who collected the samples, state of accreditation, and, if applicable, his or her accreditation number;

(iv) a list of whether the homogeneous areas identified under this subparagraph are surfacing material, thermal system insulation, or miscellaneous material;

(v) assessments made of friable material, the name and signature of each accredited inspector making the assessment, state of accreditation, and if applicable, his or her accreditation number.

(b) Reinspection

(1) At least once every three (3) years after a management plan is implemented, each local education agency shall conduct a reinspection of all friable and nonfriable known or assumed ACBM and any not previously identified suspect ACBM, regardless of whether or not these areas were included in the original inspection and management plan, in each school building that they lease, own, or otherwise use as a school building. Each local education agency shall submit to the Department within thirty (30) days of the reinspection, documentation that a reinspection has been performed. This documentation shall be submitted on a form prescribed by the Commissioner.

(2) Each inspection shall be made by an accredited inspector.

(3) For each area of a school building, each person performing a reinspection shall:

(A) visually reinspect, and reassess, under section 19a-333-6 of the regulations of Connecticut State Agencies, the condition of all friable known or assumed ACBM;

(B) visually inspect material that was previously considered nonfriable ACBM and touch the material to determine whether it has become friable since the last inspection or reinspection;

(C) visually inspect and assess under section 19a-333-6 of the regulations of Connecticut State Agencies, materials such as, but not restricted to, ceiling tile, wallboard, plaster walls, linoleum, fire doors, duct insulation and vibration dampening cloth, which are considered suspect ACBM;

(D) identify any homogeneous areas with material that has become friable since the last inspection or reinspection;

(E) for each homogeneous area of newly friable material that is already assumed to be ACBM, collect and submit bulk samples for analysis in accordance with sections 19a-333-4 and 19a-333-5 of the regulations of Connecticut State Agencies;

(F) assess, under section 19a-333-6 of the regulations of Connecticut State Agencies, the condition of the newly friable material in areas where samples are collected, and newly

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friable materials in areas that are assumed to be ACBM;

(G) reassess, under section 19a-333-6 of the regulations of Connecticut State Agencies, the condition of friable known or assumed ACBM previously identified;

(H) record the following and submit to the person designated under section 19a-333-2 of the regulations of Connecticut State Agencies a copy of such record for inclusion in the management plan within thirty (30) days of the reinspection:

(i) the date of the reinspection, the name and signature of the person making the reinspection, state of accreditation, and if applicable, his or her accreditation number, and any changes in the condition of known or assumed ACBM;

(ii) the exact locations where samples are collected during the reinspection, a description of the manner used to determine sampling locations, the name and signature of each accredited inspector who collected the samples, state of accreditation, and, if applicable, his or her accreditation number;

(iii) any assessments or reassessments made of friable material, the name and signature of the accredited inspector making the assessments, state of accreditation, and if applicable, his or her accreditation number.

(c) **General.** Thermal system insulation that has retained its structural integrity and that has an undamaged protective jacket or wrap that prevents fiber release shall be treated as nonfriable and therefore is subject only to periodic surveillance and preventive measures as necessary.

(Effective December 1, 1992)

Sec. 19a-333-4. Sampling

(a) **Surfacing material.** An accredited inspector shall collect bulk samples of surfacing material, in a statistically random manner which is representative of the homogeneous area of friable surfacing material that is not assumed to be ACM, and shall collect such samples as follows:

(1) at least three (3) bulk samples from each homogeneous area that is one-thousand (1,000) square feet or less, except as provided in subsection (d) of section 19a-333-5 of the regulations of Connecticut State Agencies;

(2) at least five (5) bulk samples shall be collected from each homogeneous area that is greater than one-thousand (1,000) square feet but less than or equal to five-thousand (5,000) square feet, except as provided in subsection (d) of section 19a-333-5 of the regulations of Connecticut State Agencies;

(3) at least seven (7) bulk samples shall be collected from each homogeneous area that is greater than five-thousand (5,000) square feet, except as provided in subsection (d) of section 19a-333-5 of the regulations of Connecticut State Agencies.

(b) **Thermal system insulation**

(1) Except as provided in subdivisions (2) through (4) of this subsection and subsection (c) of section 19a-333-5 of the regulations of Connecticut State Agencies, an accredited inspector shall collect, in a randomly distributed manner, at least three (3) bulk samples

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from each homogeneous area of thermal system insulation that is not assumed to be ACM.

(2) An accredited inspector shall collect at least one (1) bulk sample from each homogeneous area of patched thermal system insulation that is not assumed to be ACM if the patched section is less than six (6) linear or square feet.

(3) In a manner sufficient to determine whether the material is ACM or not ACM, an accredited inspector shall collect bulk samples from each insulated mechanical system that is not assumed to be ACM where cement or plaster is used on fittings such as tees, elbows, or valves, except as provided under subsection (d) of section 19a-333-5 of the regulations of Connecticut State Agencies.

(4) Bulk samples are not required to be collected from any homogeneous area where the accredited inspector has determined that the thermal system insulation is fiberglass, foam glass, rubber, or other non-ACBM.

(c) **Miscellaneous material.** In a manner sufficient to determine whether material is ACM or not ACM, an accredited inspector shall collect bulk samples from each homogeneous area of friable miscellaneous material that is not assumed to be ACM.

(d) **Nonfriable suspected ACBM.** If any homogeneous area of nonfriable suspected ACBM is not assumed to be ACM, then an accredited inspector shall collect, in a manner sufficient to determine whether the material is ACM or not ACM, bulk samples from the homogeneous area of nonfriable suspected ACBM that is not assumed to be ACM.

(Effective December 1, 1992)

Sec. 19a-333-5. Analysis

(a) Local education agencies shall have bulk samples, collected under section 19a-333-4 of the regulations of Connecticut State Agencies and submitted for analysis, analyzed for asbestos using laboratories accredited by the National Institute of Standards and Technology or an equivalent laboratory accreditation as approved by the EPA.

(b) Bulk samples shall not be composited for analysis and shall be analyzed for asbestos content by polarized light microscopy (PLM) , using the “Interim Method for the Determination of Asbestos in Bulk Insulation Samples” found at Appendix A to Subpart F in 40 CFR Part 763 as amended, or the current EPA method for the analysis of asbestos in building materials by polarized light microscopy.

(c) A homogeneous area is considered not to contain ACM only if the results of all samples required to be collected from the area show asbestos in amounts of one percent (1%) or less.

(d) A homogeneous area shall be determined to contain ACM based on a finding that the results of at least one (1) sample collected from the area shows that asbestos is present in an amount greater than one percent (1%).

(e) The name and address of each laboratory performing an analysis, the date of analysis, and the name and signature of the person performing the analysis shall be submitted to the person designated under section 19a-333-2 of the regulations of Connecticut State Agencies

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for inclusion into the management plan within thirty (30) days of the analysis.

(Effective December 1, 1992)

Sec. 19a-333-6. Assessment

(a) For each inspection and reinspection under subsections (a) and (c) of section 19a-333-3 of the regulations of Connecticut State Agencies and previous inspections specified under section 19a-333-13 of the regulations of Connecticut State Agencies, the local education agency shall have an accredited inspector provide a written assessment of all friable known or assumed ACBM in the school building.

(b) Each accredited inspector providing a written assessment shall sign and date the assessment, provide his or her state of accreditation, and if applicable, accreditation number, and submit a copy of the assessment to the person designated under section 19a-333-2 of the regulations of Connecticut State Agencies for inclusion in the management plan within thirty (30) days of the assessment.

(c) The accredited inspector shall classify and give reasons in the written assessment for classifying the ACBM and suspected ACBM assumed to be ACM in the school building into one of the following categories:

- (1) damaged or significantly damaged thermal system ACM,
- (2) damaged friable surfacing ACM,
- (3) significantly damaged friable surfacing ACM,
- (4) damaged or significantly damaged friable miscellaneous ACM,
- (5) ACBM with potential for damage,
- (6) ACBM with potential for significant damage,
- (7) any remaining friable ACBM or friable suspected ACBM.

(d) Assessment shall include the following considerations:

(1) location and the amount of the material, both in total quantity and as a percentage of the functional space;

(2) condition of the material, specifying:

(A) type of damage or significant damage (e.g., flaking, blistering, water damage, or other signs of physical damage);

(B) severity of damage (e.g., major flaking, severely torn jackets, as opposed to occasional flaking, minor tears to jackets) and

(C) extent or spread of damage over large areas or large percentages of the homogeneous area;

(3) whether the material is accessible;

(4) the material's potential for disturbance;

(5) known or suspected causes of damage or significant damage (e.g., air erosion, vandalism, vibration, water) and

(6) preventive measures which might eliminate the reasonable likelihood of undamaged ACM from becoming damaged or significantly damaged.

(e) The local education agency shall select a person accredited to develop management

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plans to review the results of each inspection, reinspection, and assessment for the school building and to conduct any other necessary activities in order to recommend in writing to the local education agency appropriate response actions. The accredited person shall sign and date the recommendation, provide his or her state of accreditation, and, if applicable, provide his or her accreditation number, and submit a copy of the recommendation to the person designated under section 19a-333-2 of the regulations of Connecticut State Agencies for inclusion in the management plan.

(Effective December 1, 1992)

Sec. 19a-333-7. Response action

(a) The local education agency shall select and implement in a timely manner the appropriate response actions in this section consistent with the assessment conducted in section 19a-333-6 of the regulations of Connecticut State Agencies. The response actions selected shall be sufficient to protect human health and the environment. The local education agency may then select, from the response actions which protect human health and the environment, that action which is the least burdensome. For purposes of determining which of these response actions is the least burdensome, the local education agency may consider local circumstances, including occupancy and use patterns within the school building, and its economic concerns, including short-term and long-term costs. The response action shall at a minimum meet the requirements as set forth in subsections (a) through (h) of this section. No asbestos abatement shall be performed in a school building while school is in session without the prior written approval of the Department.

(b) If damaged or significantly damaged thermal system insulation ACM is present in a building, the local education agency shall:

- (1) repair the damaged area; or
- (2) remove the damaged material if it is not feasible, due to technological factors, to repair the damage; and
- (3) maintain all thermal system insulation ACM and its covering in an intact state and undamaged condition.

(c) If damaged friable surfacing ACM or damaged friable miscellaneous ACM is present in a building, the local education agency shall select the response actions that best protects human health and the environment from among the following:

- (1) encapsulation
- (2) enclosure,
- (3) removal or
- (4) repair.

(d) If significantly damaged friable surfacing ACM or significantly damaged friable miscellaneous ACM is present in a building the local education agency shall:

- (1) immediately isolate the functional space and restrict access unless the accredited management planner determines that isolation is not necessary to protect human health and the environment;

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(2) remove the material in the functional space or, depending upon whether the accredited management planner determines that enclosure or encapsulation would be sufficient to protect human health and the environment, enclose or encapsulate.

(e) If any friable surfacing ACM, thermal system ACM, or friable miscellaneous ACM that has potential for damage is present in a building, the local education agency shall at least implement an O & M program, as described under section 19a-333-8 of the regulations of Connecticut State Agencies.

(f) If any friable surfacing ACM, thermal system insulation ACM, or friable miscellaneous ACM that has potential for significant damage is present in a building, the local education agency shall:

(1) implement an O & M program as described under section 19a-333-8 of the regulations of Connecticut State Agencies, and

(2) immediately isolate the area and restrict access if necessary to avoid an imminent and substantial endangerment to human health or the environment, and

(3) institute preventive measures appropriate to eliminate the reasonable likelihood that the ACM or its covering will become significantly damaged, deteriorated, or delaminated, and

(4) remove the material as soon as possible if appropriate preventive measures cannot be effectively implemented.

(g) Response actions including removal, encapsulation, enclosure, or repair, other than small-scale, short-duration repairs, shall be designed and conducted by persons accredited to design and conduct response actions.

(h) Completion of response actions

(1) At the conclusion of any action to remove, encapsulate, or enclose ACBM or material assumed to be ACBM, an accredited person designated by the local education agency shall visually inspect each functional space where such action was conducted to determine whether the action has been properly completed.

(2) An accredited person designated by the local education agency shall collect air samples using aggressive sampling as described in Appendix A to 40 CFR Part 763 Subpart E, as amended, to monitor air for clearance after each removal, encapsulation, and enclosure project involving ACBM, except for projects that are spot repairs as defined in section 19a-332a-1 of the regulations of Connecticut State Agencies.

(3) Local education agencies shall have air samples collected under this section analyzed for asbestos using laboratories accredited by the National Institute of Standards and Technology to conduct such analysis using transmission electron microscopy (TEM) or, under circumstances permitted in this section, laboratories enrolled in the American Industrial Hygiene Association Proficiency Analytical Testing Program for phase contrast microscopy (PCM).

(4) Except as provided in subdivisions (5) and (6) of this subsection, an action to remove, encapsulate, or enclose ACBM shall be considered complete when the average concentration of asbestos of five (5) air samples collected within the affected functional space and

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analyzed by the TEM method in Appendix A to 40 CFR Part 763 Subpart E, as amended, is not statistically significantly different, as determined by the Z-test calculation found in Appendix A from the average asbestos concentration of five (5) air samples collected at the same time outside the affected functional space and analyzed in the same manner, and the average asbestos concentration of the three (3) field blanks described in Appendix A is below the filter background level, as defined in Appendix A, of seventy structures per square millimeter (70 s/sq mm).

(5) An action shall also be considered complete if the volume of air drawn for each of the five (5) samples collected within the affected functional space is equal to or greater than one thousand one hundred and ninety-nine liters (1,199 L) of air for a twenty-five millimeter (25 mm) filter or equal to or greater than two thousand seven hundred and ninety-nine liters (2,799 L) of air for a thirty-seven millimeter (37 mm) filter, and the average concentration of asbestos as analyzed by the TEM method in Appendix A to 40 CFR Part 763 Subpart E, as amended, for the five (5) air samples does not exceed the filter background level, as defined in Appendix A, of seventy structures per square millimeter (70 s/sq mm). If the average concentration of asbestos of the five (5) air samples within the affected functional space exceeds seventy structures per square millimeter (70 s/sq mm), or if the volume of air in each of the samples is less than one thousand one hundred and ninety-nine liters (1,199 L) of air for a twenty-five millimeter (25 mm) filter or less than two thousand seven hundred and ninety-nine liters (2,799 L) of air for a thirty-seven millimeter (37 mm) filter the action shall be considered complete only when the requirements of subdivision (4) or (6) of this subsection are met.

(6) At any time, a local education agency may analyze air monitoring samples collected for clearance purposes by phase contrast microscopy (PCM) to confirm completion of removal, encapsulation, or enclosure of ACBM that is greater than a spot repair as defined in section 19a-332a-1 of the regulations of Connecticut State Agencies, and less than or equal to one hundred and sixty (160) square feet or two hundred and sixty (260) linear feet. The action shall be considered complete when the results of samples collected in the affected functional space and analyzed by phase contrast microscopy using the most current National Institute for Occupational Safety & Health (NIOSH) Method 7400 as amended in the Federal Register, show that the concentration of fibers for each of the five (5) samples is less than or equal to a limit of quantitation for PCM - 0.01 fibers per cubic centimeter (0.01 f/cc) of air.

(7) To determine the amount of ACBM affected under subdivision (6) of this subsection, the local education agency shall add the total square or linear footage of ACBM within the containment barriers used to isolate the functional space for the action to remove, encapsulate, or enclose the ACBM. Contiguous portions of material subject to such action conducted concurrently or at approximately the same time within the same school building shall not be separated to qualify under subdivision (6) of this subsection.

(i) The requirements of this section in no way supersede the worker protection and work

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practice requirements under any applicable state regulations.

(Effective December 1, 1992)

Sec. 19a-333-8. Operations and maintenance (O & M)

(a) **Applicability.** The local education agency shall implement an O & M program under this section whenever any friable ACBM is present or assumed to be present in a building that it leases, owns, or otherwise uses as a school building. Any material identified as nonfriable ACBM or nonfriable assumed ACBM must be treated as friable ACBM for purposes of this section when the material is about to become friable as a result of activities performed in the school building.

(b) **Cleaning**

(1) Initial cleaning. Unless the building has been cleaned using equivalent methods within the previous six (6) months, all areas of a school building where friable ACBM, damaged or significantly damaged thermal system insulation ACM, or friable suspected ACBM assumed to be ACM are present shall be cleaned at least once after the completion of the required initial inspection under subsection (a) of section 19a-333-3 of the regulations of Connecticut State Agencies and before the initiation of any response action, other than O & M activities or repair, according to the following procedures:

- (A) HEPA-vacuum or steam-clean all carpets, and
- (B) HEPA-vacuum or wet-clean all other floors and all other horizontal surfaces, and
- (C) Dispose of all debris, filters, mopheads, and cloths in sealed, leak-tight containers.

(2) Additional cleaning. The accredited management planner shall make a written recommendation to the local education agency whether additional cleaning is needed, and if so, the methods and frequency of such cleaning.

(c) **Operations and maintenance activities.** The local education agency shall ensure that the procedures described below to protect building occupants shall be followed for any operations and maintenance activities disturbing friable ACBM.

(1) Restrict entry into the area by persons other than those necessary to perform the maintenance project, either by physically isolating the area or by scheduling.

(2) Post signs to prevent entry by unauthorized persons.

(3) Shut off or temporarily modify the air-handling system and restrict other sources of air movement.

(4) Use work practices or other controls, such as: wet methods, protective clothing, HEPA-vacuums, mini-enclosures or glove bags, as necessary to inhibit the spread of any released fibers.

(5) Clean all fixtures or other components in the immediate work area.

(6) Place the asbestos debris and other cleaning materials in a sealed, leak-tight container.

(d) **Maintenance activities other than spot repairs.** The response action for any maintenance activities disturbing friable ACBM, other than spot repairs, shall be designed by persons accredited to design response actions and conducted by persons accredited to conduct response actions.

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(e) Fiber release episodes

(1) Minor fiber release episode. The local education agency shall ensure that the procedures described below are followed in the event of a minor fiber release episode (i.e., the falling or dislodging of three (3) square or linear feet or less of friable ACBM).

(A) Thoroughly saturate the debris using wet methods.

(B) Clean the area, as described in subsection (d) of this section.

(C) Place the asbestos debris in a sealed, leak-tight container.

(D) Repair the area of damaged ACM with materials such as; asbestos-free spackling, plaster, cement, or insulation; or seal with latex paint or an encapsulant; or immediately have the appropriate response action implemented as required by section 19a-333-7 of the regulations of Connecticut State Agencies.

(2) Major fiber release episode. The local education agency shall ensure that the procedures described below are followed in the event of a major fiber release episode (i.e., the falling or dislodging of more than three (3) square or linear feet of friable ACBM).

(A) Restrict entry into the area and post signs to prevent entry into the area by persons other than those necessary to perform the response action.

(B) Shut off or temporarily modify the air-handling system to prevent the distribution of fibers to other areas in the building.

(C) The response action for any major fiber release episode must be designed by persons accredited to design response actions and conducted by persons accredited to conduct response actions.

(D) The local education agency shall notify the Department of any major fiber release episode within twenty-four (24) hours of its occurrence and, if necessary provide written notification as required by applicable federal and/or state regulations.

(Effective December 1, 1992)

Sec. 19a-333-9. Training and periodic surveillance

(a) Training

(1) The local education agency shall ensure, prior to the implementation of the O & M provisions of the management plan, that all members of its maintenance and custodial staff (custodians, electricians, heating/air conditioning engineers, plumbers, etc.) who may work in a building that contains ACBM receive awareness training of at least two (2) hours, whether or not they are required to work with ACBM. New custodial and maintenance employees shall be trained within sixty (60) days after commencement of employment. Training shall include, but not be limited to:

(A) information regarding asbestos and its various uses and forms,

(B) information on the health effects associated with asbestos exposure,

(C) locations of ACBM identified throughout each school building in which they work,

(D) recognition of damage, deterioration, and delamination of ACBM,

(E) name and telephone number of the person designated to carry out general local education agency responsibilities under section 19a-333-2 of the regulations of Connecticut

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State Agencies and the availability and location of the management plan.

(2) The local education agency shall ensure that all members of its maintenance and custodial staff who conduct any activities that will result in the disturbance of ACBM shall receive training described in subdivision (1) of this subsection and fourteen (14) hours of additional training. Additional training shall include, but not be limited to:

(A) descriptions of the proper methods of handling ACBM;

(B) information on the use of respiratory protection as contained in the EPA/NIOSH Guide to Respiratory Protection for the Asbestos Abatement Industry, September 1986 (EPA 560/OPTS-86-001), as amended, and other personal protection measures;

(C) the provisions of: this section and section 19a-333-8 of the regulations of Connecticut State Agencies, Appendices A, B, C, D to Subpart E of 40 CFR Part 763, EPA regulations contained in 40 CFR Part 763, Subpart G, and in 40 CFR Part 61, Subpart M, and OSHA regulations contained in 29 CFR 1926.58, as respectively amended; and

(D) hands-on training in the use of respiratory protection, other personal protection measures, and good work practices.

(3) Local education agency maintenance and custodial staff who have attended a training program accredited under the EPA Model Accreditation Plan which includes as a minimum all of the training requirements listed in this section, shall be considered trained for the purposes of the section.

(b) Periodic surveillance

(1) At least once every six (6) months after a management plan is in effect, each local education agency shall conduct periodic surveillance in each building that it leases, owns, or otherwise uses as a school building that contains ACBM or is assumed to contain ACBM. The reinspection required every three (3) years under subsection (b) of section 19a-333-3 of the regulations of Connecticut State Agencies will satisfy the six (6) month periodic surveillance requirement if the reinspection coincides with the date of the six (6) month surveillance inspection.

(2) Each person performing periodic surveillance shall:

(A) Visually inspect all areas that are identified in the management plan as ACBM or assumed ACBM;

(B) record the date of the surveillance, his or her name, and any changes in the condition of the materials; and

(C) submit to the person designated to carry out general local education agency responsibilities under section 19a-333-2 of the regulations of Connecticut State Agencies a copy of such record for inclusion in the management plan.

(Effective December 1, 1992)

Sec. 19a-333-10. Management plans

(a) Each local education agency shall develop an asbestos management plan for each school, including all buildings that they lease, own, or otherwise use as school buildings, and submit the plan to the Department.

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(1) Any asbestos management plan developed under the Act, before December 31, 1992, and submitted to the State pursuant to the Act, shall satisfy the requirements of this section for any building covered by said plan.

(2) If any building or part of any building to be used as a school is leased or acquired after December 31, 1992, the local education agency shall include the building or part of the building in the management plan prior to its use or occupancy of the building or part of the building as a school. The management plan shall be submitted to the Department and approved prior to use or occupancy of the building or part of the building as a school.

(b) The Department shall review and either approve or disapprove the management plan.

(c) Each local education agency must implement its management plan prior to its use or occupancy of the building or part of the building as a school, and complete implementation based on the schedule approved by the Department.

(d) Each local education agency shall maintain and update its management plan to keep it current with ongoing operations and maintenance, periodic surveillance, inspection, reinspection, and response action activities. All provisions required to be included in the management plan under this section shall be retained as part of the management plan, as well as any information that has been revised to bring the plan up-to-date.

(e) The management plan shall be developed by an accredited management planner and shall include:

(1) a list of the name and address of each school building and whether the school building contains friable ACBM, nonfriable ACBM and friable and nonfriable suspected ACBM assumed to be ACM;

(2) a list of specific steps or actions to be completed prior to the use or occupancy of the building or part of the building as a school;

(3) for each inspection conducted before December 14, 1987:

(A) the date of the inspection,

(B) a blueprint, diagram, or written description of each school building that identifies clearly each location and approximate square or linear footage of any homogeneous or sampling area where material was sampled for ACM, and, if possible, the exact locations where bulk samples were collected, and the dates of collection,

(C) a copy of the analyses of any bulk samples, dates of analyses, and a copy of any other laboratory reports pertaining to the analyses.

(D) a description of any response actions or preventive measures taken to reduce asbestos exposure including, if possible, the names and addresses of all contractors involved, start and completion dates of the work, and results of any air samples analyzed during and upon completion of the work,

(E) a description of assessments, required to be made under section 19a-333-6 of the regulations of Connecticut State Agencies, of material that was identified before December 14, 1987, as friable ACBM or friable suspected ACBM assumed to be ACM, and the name, signature, and state of accreditation, and if applicable, accreditation number of each accredited person making the assessments;

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(4) for each inspection and reinspection conducted under section 19a-333-3 of the regulations of Connecticut State Agencies:

(A) the date of the inspection or reinspection, and the name and signature, state of accreditation and, if applicable, the accreditation number of each accredited inspector performing the inspection or reinspection.

(B) a blueprint, diagram, or written description of each school building which identifies clearly each location and approximate square or linear footage of homogeneous areas where material was sampled for ACM, the exact location where each bulk sample was collected, date of collection, homogeneous areas where friable suspected ACBM is assumed to be ACM, and where nonfriable suspected ACBM is assumed to be ACM,

(C) a description of the manner used to determine sampling locations, and the name and signature of each accredited inspector collecting samples, the state of accreditation, and if applicable, his or her accreditation number,

(D) a copy of the analyses of any bulk samples collected and analyzed, the name and address of any laboratory that analyzed bulk samples, a statement that the laboratory meets the applicable requirements of subsection (a) of section 19a-333-5 of the regulations of Connecticut State Agencies, the date of analysis, and the name and signature of the person performing the analysis,

(E) a description of assessments, required to be made under section 19a-333-6 of the regulations of Connecticut State Agencies, of all ACBM and suspected ACBM assumed to be ACM, and the name, signature, state of accreditation, and if applicable, accreditation number of each accredited person making the assessments.

(5) the name, address, and telephone number of the person designated under section 19a-333-2 of the regulations of Connecticut State Agencies to ensure that the duties of the local education agency are carried out, and the course name, and dates and hours of training taken by that person to carry out the duties;

(6) the recommendations made to the local education agency regarding response actions, under subsection (e) of section 19a-333-6 of the regulations of Connecticut State Agencies, the name, signature, state of accreditation of each person making the recommendations, and if applicable, his or her accreditation number;

(7) a detailed description of preventive measures and response actions to be taken, including methods to be used for any friable ACBM, the locations where such measures and action will be taken, reasons for selecting the response action or preventive measure, and a schedule for beginning and completing each preventive measure and response action;

(8) with respect to the person or persons who inspected for ACBM and who will design or carry out response actions, except for operations and maintenance with respect to the ACBM, a statement that the person is accredited;

(9) a detailed description, which shall be updated as response actions are completed, in the form of a blueprint, diagram, or in writing of any ACBM or suspected ACBM assumed to be ACM which remains in the school once response actions are undertaken pursuant to section 19a-333-7 of the regulations of Connecticut State Agencies;

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(10) a plan for reinspection under section 19a-333-3 of the regulations of Connecticut State Agencies, a plan for operations and maintenance activities under section 19a-333-8 of the regulations of Connecticut State Agencies, and a plan for periodic surveillance under section 19a-333-9 of the regulations of Connecticut State Agencies, a description of the recommendation made by the management planner regarding additional cleaning under subdivision (2) of subsection (b) of section 19a-333-8 of the regulations of Connecticut State Agencies as part of an operations and maintenance program, and the response of the local education agency to that recommendation;

(11) a description of steps taken to inform workers and building occupants, or their legal guardians, about inspections, reinspections, response actions, and post-response action activities, including periodic reinspection and surveillance activities that are planned or in progress;

(12) an evaluation of the resources needed to complete response actions successfully and carry out reinspection, operations and maintenance, periodic surveillance and training;

(13) with respect to each consultant who contributed to the management plan, the name of the consultant and a statement that the consultant is accredited.

(f) Upon submission of a management plan to the Department for review, a local education agency shall maintain in its administrative office a complete, updated copy of a management plan for each school under its administrative control or direction.

(1) The management plans shall be available, without cost or restriction, for inspection by representatives of EPA and the State, the public, including teachers, other school personnel and their representatives, and parents. The local education agency may charge a reasonable cost to make copies of management plans.

(2) Each school shall maintain in its administrative office a complete, updated copy of the management plan for that school. Management plans shall be available for inspection, without cost or restriction, to workers before work begins in any area of a school building. The school shall make management plans available upon demand for inspection to representatives of EPA and the State. The school shall make management plans available to the public, including parents, teachers, and other school personnel and their representatives within five (5) working days after receiving a request for inspection. The school may charge a reasonable cost to make copies of the management plan.

(3) Upon submission of its management plan to the Department and at least once each school year, the local education agency shall notify in writing parents, teachers, and employee organizations of the availability of management plans and shall include in the management plan a description of the steps taken to notify such organizations, and a dated copy of the notification. In the absence of any such organizations for parents, teachers, or employees, the local education agency shall provide written notice to that relevant group of the availability of management plans and shall include in the management plan a description of the steps taken to notify such groups, and a dated copy of the notification.

(g) Records required under section 19a-333-11 of the regulations of Connecticut State Agencies shall be made by local education agencies and maintained as part of the

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management plan.

(h) Each management plan must contain a true and correct statement, signed by the individual designated by the local education agency under section 19a-333-2 of the regulations of Connecticut State Agencies, which certifies that the general local education agency responsibilities, as stipulated by section 19a-333-2 of the regulations of Connecticut State Agencies, have been met or will be met.

(Effective December 1, 1992)

Sec. 19a-333-11. Recordkeeping

(a) Records required under this section shall be maintained in a centralized location in the administrative office of both the school and the local education agency as part of the management plan. For each homogeneous area where all ACBM has been removed, the local education agency shall ensure that such records are retained for three (3) years after the next reinspection required under subdivision (1) of subsection (b) of section 19a-333-3 of the regulations of Connecticut State Agencies.

(b) For each preventive measure and response action taken for friable and nonfriable ACBM and friable and nonfriable suspected ACBM assumed to be ACM, the local education agency shall maintain as part of the management plan the following:

(1) a detailed written description of the measure or action, including methods used, the location where the measure or action was taken, reasons for selecting the measure or action, start and completion dates of the work, names and addresses of all contractors involved, and if applicable, their state of accreditation, and accreditation numbers, and if ACBM is removed, the name and location of storage or disposal site of the ACM;

(2) the name and signature of any person collecting any air sample required to be collected at the completion of certain response actions specified by subsection (h) of section 19a-333-7 of the regulations of Connecticut State Agencies, the locations where samples were collected, date of collection, the name and address of the laboratory analyzing the samples, the date of analysis, the results of the analysis, the method of analysis, the name and signature of the person performing the analysis, and a statement that the laboratory meets the applicable requirements of subdivision (3) of subsection 19a-333-7 (h) of the regulations of Connecticut State Agencies.

(c) For each person required to be trained under subdivisions (1) and (2) of subsection (a) of section 19a-333-9 of the regulations of Connecticut State Agencies, the local education agency shall record the person's name and job title, the date that training was completed by that person, the location of the training, and the number of hours completed in such training.

(d) For each time that periodic surveillance under subsection (b) of section 19a-333-9 of the regulations of Connecticut State Agencies is performed, the local education agency shall record the name of each person performing the surveillance, the date of the surveillance, and any changes in the conditions of the materials.

(e) For each time that cleaning under subsection (b) of section 19a-333-8 of the regulations of Connecticut State Agencies is performed, the local education agency shall

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record the name of each person performing the cleaning, the date of such cleaning, the locations cleaned, and the methods used to perform such cleaning.

(f) For each time that an operations and maintenance activity under subsection (c) of section 19a-333-8 of the regulations of Connecticut State Agencies is performed, the local education agency shall record the name of each person performing the activity, the start and completion dates of the activity, the locations where such activity occurred, a description of the activity including preventive measures used, and if ACBM is removed, the name and location of the storage or disposal site of the ACM.

(g) For each time that major asbestos activity under subsection (d) of section 19a-333-8 of the regulations of Connecticut State Agencies is performed, the local education agency shall record the name and signature, state of accreditation, and if applicable, the accreditation number of each person performing the activity, the start and completion dates of the activity, the locations where such activity occurred, a description of the activity including preventive measures used, and if ACBM is removed, the name and location of the storage or disposal site of the ACM.

(h) For each fiber release episode under subsection (e) of section 19a-333-8 of the regulations of Connecticut State Agencies, the local education agency shall record the date and location of the episode, the method of repair, preventive measures or response action taken, the name of each person performing the work, and if ACBM is removed, the name and location of the storage or disposal site of ACM.

(Effective December 1, 1992)

Sec. 19a-333-12. Warning labels

(a) The local education agency shall attach a warning label adjacent to any friable or nonfriable ACBM or suspected ACBM assumed to be ACM located in routine maintenance areas (such as boiler rooms) at each school building. These labels shall be placed adjacent to the following locations:

- (1) friable ACBM for which the response was any action other than removal, and
- (2) ACBM for which no response action was carried out.

(b) All labels shall be of large size and prominently displayed in readily visible locations so that persons may read the signs and take necessary protective steps before entering the area. All labels shall remain posted until the ACBM that is labeled is removed.

(c) The warning label shall read, in black print on a contrasting yellow background, as follows:

CAUTION: ASBESTOS, HAZARDOUS, DO NOT DISTURB WITHOUT PROPER TRAINING AND EQUIPMENT.

(d) The local education agency shall post these labels in a bilingual form whenever it determines that a significant student and/or employee population requires a translated format.

(Effective December 1, 1992)

Sec. 19a-333-13. Exclusions

(a) A local education agency shall not be required to perform an inspection under subsection (a) of section 19a-333-3 of the regulations of Connecticut State Agencies in any sampling area or homogeneous area of a school building where any of the following conditions apply.

(1) An accredited inspector has determined that, based on sampling records, friable ACBM was identified in that homogeneous or sampling area during an inspection conducted before December 14, 1987. The inspector shall sign and date a statement to that effect with his or her state of accreditation and if applicable, accreditation number and, within thirty (30) days after such determination, submit a copy of the statement to the person designated under section 19a-333-2 of the regulations of Connecticut State Agencies for inclusion in the management plan. However, an accredited inspector shall assess the friable ACBM under section 19a-333-6 of the regulations of Connecticut State Agencies.

(2) An accredited inspector has determined, based on sampling records, that nonfriable ACBM was identified in that homogeneous or sampling area during an inspection conducted before December 14, 1987. The inspector shall sign and date a statement to that effect with his or her state of accreditation and if applicable, accreditation number and, within thirty (30) days after such determination, submit a copy of the statement to the person designated under section 19a-333-2 of the regulations of Connecticut State Agencies for inclusion in the management plan. However, an accredited inspector shall identify whether material that was nonfriable has become friable since that previous inspection and shall assess the newly friable ACBM under section 19a-333-6 of the regulations of Connecticut State Agencies.

(3) Based on sampling records and inspection records, an accredited inspector has determined that no ACBM is present in the homogeneous or sampling area and the records show that the area was sampled, before December 14, 1987, in substantial compliance with subsection (a) of section 19a-333-3 of the regulations of Connecticut State Agencies, which for purposes of this subsection means in a random manner and with a sufficient number of samples to reasonably ensure that the area is not ACBM.

(A) The accredited inspector shall sign and date a statement, with his or her state of accreditation and if applicable accreditation number, that the homogeneous or sampling area determined not to be ACBM was sampled in substantial compliance with subsection (a) of section 19a-333-3 of the regulations of Connecticut State Agencies.

(B) Within thirty (30) days after the inspector's determination, the local education agency shall submit a copy of the inspector's statement to the Department and shall include the statement in the management plan for that school.

(4) An accredited inspector has determined, based on records of an inspection conducted before December 14, 1987, that suspected ACBM identified in that homogeneous or sampling area is assumed to be ACM. The inspector shall sign and date a statement to that effect, with his or her state of accreditation and if applicable, accreditation number and, within thirty (30) days of such determination, submit a copy of the statement to the person designated under section 19a-333-2 of the regulations of Connecticut State Agencies for

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inclusion in the management plan. However, an accredited inspector shall identify whether material that was nonfriable suspected ACBM assumed to be ACM has become friable since the previous inspection and shall assess the newly friable material and previously identified friable suspected ACBM assumed to be ACM under section 19a-333-6 of the regulations of Connecticut State Agencies.

(5) Based on inspection records and contractor and clearance records, an accredited inspector has determined that no ACBM is present in the homogeneous or sampling area where asbestos removal operations have been conducted before December 14, 1987, and shall sign and date a statement to that effect and include his or her state of accreditation and, if applicable, accreditation number. The local education agency shall submit a copy of the statement to the Department and shall include the statement in the management plan for that school.

(6) An architect or project engineer responsible for the construction of a new school building built after October 12, 1988, or an accredited inspector signs a statement that no ACBM was specified as a building material in any construction document for the building, or, to the best of his or her knowledge, no ACBM was used as a building material in the building. The local education agency shall submit a copy of the signed statement of the architect, project engineer, or accredited inspector to the Department and shall include the statement in the management plan for that school.

(b) The exclusions, under subdivisions (1) through (3) of subdivision (a) of this section, from conducting the inspection under subsection (a) of section 19a-333-3 of the regulations of Connecticut State Agencies shall apply only to homogeneous or sampling areas of a school building that were inspected and sampled before October 17, 1987. The local education agency shall conduct an inspection under subsection (a) of section 19a-333-3 of the regulations of Connecticut State Agencies of all areas inspected before October 17, 1987, that were not sampled or were not assumed to be ACM.

(c) If ACBM is subsequently found in a homogeneous or sampling area of a local education agency that had been identified as receiving an exclusion by an accredited inspector under subdivision (3) or (4) of subsection (a) of this section, or by an architect, project engineer or accredited inspector under subdivision (6) of subsection (a) of this section, the local education agency shall have one hundred and eighty (180) days following the date of identification of ACBM to comply with these regulations.

(Effective December 1, 1992)

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Agency

Commission on Medicolegal Investigations

Subject

**Operation of Commission on Medicolegal Investigations Reports of Death, Suicide
Notes and Personal Data**

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Notes and Personal Data**

Sec. 19a-401-1. Definitions

- (a) “Commission” shall mean the Commission on Medicolegal Investigations.
- (b) “Office” shall mean the Office of the Chief Medical Examiner.
- (c) “Institutions” shall mean any institution defined in Section 19a-490 of the Connecticut General Statutes.

(Effective June 23, 1986; Amended September 3, 1998)

Sec. 19a-401-2. Commission on medicolegal investigations

The Commission shall operate in accordance with the “Medicolegal Investigations Act,” Chapter 368q of the Connecticut General Statutes. The powers and duties of the Commission shall include but not be limited to the following:

- (a) Appoint the chief medical examiner pursuant to Sections 19a-403 and 19a-404 of the Connecticut General Statutes and Section 19a-401-3 of these regulations;
- (b) Oversee the operations of the Office of the Chief Medical Examiner;
- (c) Approve of the Office procedures manual and organizational chart;
- (d) Approve of numbers and qualifications of professional staff.

(Effective June 23, 1986; Amended September 3, 1998)

Sec. 19a-401-3. Qualifications of staff

(a) **Chief Medical Examiner.** The chief medical examiner shall meet all qualifications specified in Section 19a-404 of the Connecticut General Statutes and shall be certified by the American Board of Pathology in forensic pathology.

(b) **Deputy Chief Medical Examiner.** The deputy chief medical examiner shall meet all of the qualifications required for the chief medical examiner in subsection (a) above.

(c) **Associate Medical Examiners.** Associate medical examiners shall meet all qualifications specified in the State of Connecticut job specification, “Associate Medical Examiner.”

(d) **Assistant Medical Examiners.** Assistant medical examiners shall have the following qualifications:

- (1) A current license to practice medicine and surgery in Connecticut; and
- (2) Compliance with continuing medical education requirements as specified in Sec. 19a-401-5 of these regulations.

(e) **Director, Toxicology Laboratory.** The director of toxicology laboratory shall meet all qualifications specified in the State of Connecticut job specification, “Director of Toxicology Laboratory, Office of the Chief Medical Examiner”.

(Effective June 23, 1986; Amended September 3, 1998)

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Sec. 19a-401-4. Powers and duties of the chief medical examiner

The chief medical examiner shall have the following duties and responsibilities:

(a) Investigation of human deaths in accordance with subsections (a) and (c) of Section 19a-406.

(b) Appointment, with the Commission's approval, of a deputy chief medical examiner to act on behalf of the chief medical examiner in the chief's absence, and other professional staff in accordance with Section 19a-405 of the Connecticut General Statutes and Section 19a-401-3 of these regulations;

(c) Designation of certified pathologists in accordance with Section 19a-406 (b) of the Connecticut General Statutes;

(d) Removal of assistant medical examiners, in accordance with Section 19a-401-7 of these regulations;

(e) Development of continuing medical education, in accordance with Section 19a-401-5 of these regulations;

(f) Development of an organizational chart, including written definition of the duties and responsibilities of all personnel classifications;

(g) Research in pathology.

(Effective June 23, 1986; Amended September 3, 1998)

Sec. 19a-401-5. Continuing medical education

(a) The chief medical examiner shall ensure the availability of continuing education in forensic medicine. Such educational programs shall be developed and administered by the Office and shall be offered at least annually in locations throughout the state.

(b) Each assistant medical examiner and designated certified pathologist shall attend annually at least six hours of continuing medical education in forensic medicine pursuant to subsection (a) above, except that accredited programs offered under other auspices may be approved by the chief medical examiner as complying with this section. Documentation of attendance shall be provided to the Office. Failure to demonstrate compliance with this section during a calendar year may be grounds for removal or withdrawal of designation.

(Effective June 23, 1986; Amended September 3, 1998)

Sec. 19a-401-6. Staff identification required

Any medical examiner shall carry an identification issued by the Office at all times while acting in the official capacity on behalf of the Office. The card shall contain the name, title and photograph of the individual and the name, address and telephone number of the Office and shall be signed by the chief medical examiner.

(Effective June 23, 1986; Amended September 3, 1998)

Sec. 19a-401-7. Removal of assistant medical examiners

Any assistant medical examiner may be removed at the discretion of the commission

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upon the recommendation of the chief medical examiner.

(Effective June 23, 1986; Amended September 3, 1998)

Sec. 19a-401-8. Timely submission of reports

Assistant medical examiners shall mail, or otherwise deliver, to the Office reports of their investigation of a death no later than ten working days after the investigation is complete. Payment for investigations may be denied if the reports are not submitted in a timely fashion.

(Effective June 23, 1986; Amended September 3, 1998)

Sec. 19a-401-9. Reporting of deaths

(a) Deaths in institutions.

(1) Deaths in institutions shall be reported to the Office in accordance with subdivision (2) below if death occurs:

(A) As specified in Connecticut General Statutes Sec. 19a-406;

(B) Within 24 hours of admission;

(C) In a sudden or unexpected fashion;

(D) During or related to a therapeutic or diagnostic procedure;

(E) In an operating room or recovery room; or

(F) If there is evidence of abuse or neglect in causing the death.

(2) Any death occurring as described in subdivision (1) above shall be immediately reported to the Office by telephone. A report of death, on the form issued by the office, shall be completed, signed and sent to the office of The Chief Medical Examiner, 11 Shuttle Rd., Farmington, CT 06032 within ten calendar days of death.

(b) Deaths Occurring Outside Institutions.

When any death subject to investigation by the Office occurs, the police department having primary responsibility for the investigation of such death shall immediately telephone the Office and shall give at least the following information:

(1) the name, age, race and sex of the deceased, if known;

(2) the place and apparent manner of death;

(3) the time the death was discovered.

(c) When the body is initially unidentified, and subsequent identification is made by comparison of fingerprints, that police department shall notify the Office in writing of the correct name, age and address of the deceased person so identified.

(Effective June 23, 1986; Amended September 3, 1998; Amended February 2, 2004)

Sec. 19a-401-10. Changes in certificate of death

(a) In any death subject to investigation by the chief medical examiner, the identification of the deceased or cause or manner of death, as listed on the certificate of death as initially recorded by the registrar of vital statistics or ex officio registrar of vital statistics, shall not be changed, modified, altered, or added to without the written authorization of the Office.

(b) When there is any change in the identification of the deceased or cause or manner of

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death, as initially recorded by the registrar of vital statistics, the chief medical examiner shall clearly indicate on the records at the Office any such change and shall mail to the registrar of vital statistics or ex officio registrar of vital statistics, notification of such change.

(Effective June 23, 1986; Amended September 3, 1998)

Sec. 19a-401-11. Repealed

Repealed February 2, 2004.

Sec. 19a-401-12. Reports and forms; inquiries; records

(a) **Reports of investigations and of autopsies are prepared on standard forms issued by the Office of the Medical Examiner.** The original reports of investigations, reports of hospital deaths, and of authorized autopsies are transmitted to the Office of the Medical Examiner and copies are obtainable only from the Chief Medical Examiner. The standard forms utilized by the Office of the Medical Examiner include: (1) telephone notice of death; (2) report of investigation; (3) hospital report of death; (4) identification form; (5) autopsy report; (6) receipt of evidence.

(b) **Retention of records; inspection of records.** The Office of the Medical Examiner keeps full and complete records of every death reported and investigated. They are retained at the Office of the Medical Examiner. The original records shall be disposed of in accordance with section 11-8a of the Connecticut general statutes.

(c) **Inquiries and requests for copies of records.** Inquiries concerning a death may be made in person or by letter to the Chief Medical Examiner, Office of the Medical Examiner, 11 Shuttle Rd., Farmington, Connecticut 06032. Copies of reports prepared by personnel of the Office of the Medical Examiner, Assistant Medical Examiners and designated pathologists and other laboratories where pertinent, or detailed findings of other scientific investigations, are furnished upon payment of fees and upon conditions established by the Commission on Medicolegal Investigations. Copies of such reports may be obtained as follows:

(1) If the requester of the records is a public authority, professional, medical, legal or scientific body or university or similar research body, seeking access to records for scientific or research purposes, access to the records is in the discretion of the commission. Such persons should address a letter to the chief medical examiner stating the general purposes for which access to the records is required and stipulating under oath that the identity of the deceased persons or any references which might result in the disclosure of the identity of the deceased persons, shall remain confidential and not be published.

(2) If the requester of the records is a member of the general public, he or she may obtain access to such records if the person has a legitimate interest in the documents and no court has issued an order prohibiting disclosure pursuant to section 19a-411(c) of the Connecticut general statutes.

(3) If the requester of the records is a member of the general public and the records concern a person in the custody of the state at the time of death, as defined in section 19a-

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411(b) of the Connecticut general statutes, he or she may obtain access to such records if no court has issued an order prohibiting disclosure pursuant to section 19a-411(c) of the Connecticut general statutes.

(4) If the requester of the records is a pro se litigant seeking access to medical records, he or she may obtain access to such records if the records are legitimately sought for pending litigation and no court has issued an order prohibiting disclosure pursuant to section 19a-411(c) of the Connecticut General Statutes. Such person should address a letter to the chief medical examiner stating the case name, docket number, court where the litigation is pending, and why the requester believes these records reasonably relate to his or her case.

(d) Requests for copies of records should be in writing addressed to the Chief Medical Examiner, Office of the Medical Examiner, 11 Shuttle Rd., Farmington, Connecticut 06032. Requests for copies of records will be accepted in person during normal business hours upon such conditions as indicated for written requests and provided that such requests will not interfere with the normal operations of the Office of the Medical Examiner. Requests for copies of records should list the name of the deceased, date of death and place of death.

(e) Requests for records sought by an attorney acting on behalf of an estate should be accompanied by a duly executed authorization by the executor or administrator of the estate. Requests by attorneys, insurance claims agents or other interested parties, other than the next of kin or persons acting on behalf of the next of kin, should state reasons for which records are required.

(f) Upon receipt of request from defense counsel of record in a criminal case for copies of reports in said case, the Chief Medical Examiner shall promptly notify the Office of the State's Attorney which has jurisdiction of such request and shall release said records to the defense attorney after the expiration of 10 working days from the date of receipt of such request, without charge therefor, unless the Chief Medical Examiner is notified within said period of time that an application limiting disclosure has been made by the State's Attorney pursuant to provisions of Section 19a-411 of the Connecticut General Statutes and that an order limiting disclosure has been issued by a judge for the judicial district in which the state's attorney has jurisdiction.

(g) The following records will be furnished upon payment of the following fees, payable to the Treasurer, State of Connecticut, prescribed by the Commission on Medicolegal Investigations for copying such records and, where requested, for certification:

1 Telephone Notice of Death	\$2.00 per page
2 Report of Investigation	\$2.00 per page
3 Hospital Report of Death	\$2.00 per page
4 Identification Form	\$2.00 per page
5 Autopsy Report	\$2.00 per page
6 Report of Toxicologic Analysis	\$2.00 per page

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7 Receipt of Evidence \$2.00 per page

8 Certification as True Copy \$5.00 per certification

(h) The records of the Office of the Medical Examiner may also contain copies of records of hospitalization, reports of police investigation, coroner's findings and copies of certificates of death. These records are subject to the freedom of information act, as defined in section 1-200 of the Connecticut general statutes.

(Effective June 23, 1986; Amended September 3, 1998; Amended February 2, 2004; Amended November 14, 2006)

Sec. 19a-401-13. Request for regulation

These rules set forth the procedure to be followed by the Commission on Medicolegal Investigations in the disposition of petitions concerning the promulgation, amendment, or repeal of a regulation governing the duties of the Chief Medical Examiner and the administration of the Office of the Medical Examiner.

(Effective June 23, 1986; Amended September 3, 1998; Amended February 2, 2004)

Sec. 19a-401-14. Form of petition

Any interested person may at any time petition the Commission to promulgate, amend, or repeal any regulation. The petition shall set forth clearly and concisely the text of the proposed regulation, amendment or repeal. Such petition shall also state the facts and arguments that favor the action it proposes either in the petition or in a brief annexed thereto. The petition shall be addressed to the Chairman of the Commission and sent to him by mail to the Office of the Medical Examiner, 11 Shuttle Rd., Farmington, Connecticut 06032 or delivered in person during normal business hours. The petition shall be signed by the petitioner and shall furnish the address of the petitioner and the name and address of the petitioner's attorney, if applicable.

(Effective June 23, 1986; Amended September 3, 1998)

Sec. 19a-401-15. Procedure after petition filed

(a) **Decision on petition.** The Commission shall within 30 days after submission of the petition either deny the petition in writing stating its reasons for the denial or shall initiate regulation-making proceedings in accordance with Section 4-168 of the Connecticut General Statutes.

(b) **Procedure on denial.** If the Commission denies the petition, the Chairman of the Commission shall give the petitioner notice in writing stating the reasons for the denial based upon the data, facts, and arguments submitted with the petition by the petitioner and upon such additional data, facts, and arguments as the Commission shall deem appropriate.

(Effective June 23, 1986; Amended September 3, 1998; Amended February 2, 2004)

Sec. 19a-401-16. Requests for declaratory rulings. General

These rules set forth the procedure to be followed by the Commission in the disposition

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of requests for declaratory rulings as to the validity of any regulation, or the applicability to specified circumstances of a provision of the Connecticut General Statutes, a regulation or a final decision within the Commission's jurisdiction.

(Effective June 23, 1986; Amended September 3, 1998; Amended February 2, 2004)

Sec. 19a-401-17. Form of request for declaratory ruling

A request for declaratory ruling shall be addressed to the Commission and sent to the Chairman of the Commission on Medicolegal Investigations by mail to the Office of the Medical Examiner, 11 Shuttle Rd., Farmington, Connecticut 06032 or delivered in person during normal business hours. The request shall be signed by the person in whose behalf the inquiry is made or by his attorney. It shall give the address of the person inquiring and the name and address of such person's attorney, if applicable. The request shall clearly and concisely state the substance and nature of the request. It shall identify the statute, the regulation or order concerning which the inquiry is made and shall identify the particular aspect thereof to which the inquiry is directed. The request for a declaratory ruling shall be accompanied by a statement of any data, facts and arguments that support the position of the person making the inquiry.

(Effective June 23, 1986; Amended September 3, 1998; Amended February 2, 2004)

Sec. 19a-401-18. Procedure after request filed

(a) **Notice to other persons.** Within 30 days after receipt of a request for a declaratory ruling, the Commission shall give notice of the request to all persons to whom notice is required by any provision of law and to all persons who have requested notice of declaratory ruling requests on the subject matter of the request, as required by section 4-176 of the Connecticut General Statutes.

(b) **Provision for hearing.** If the Commission deems a hearing necessary or helpful in determining any issue concerning the request for an declaratory ruling, the Commission shall schedule such hearing and give such notice thereof as shall be appropriate.

(c) **Decision on Request.** Within 60 days after receipt of a request for a declaratory ruling, the commission shall: (1) issue a ruling declaring the validity of a regulation or the applicability of the provision of the General Statutes, the regulation, or the final decision in question to the specified circumstances; (2) order the matter set for specified proceedings; (3) agree to issue a declaratory ruling by a specified date; (4) decide not to issue a declaratory ruling and initiate regulation-making proceedings, under section 4-168 of the Connecticut General Statutes, on the subject; or (5) decide not to issue a declaratory ruling, stating the reasons for its action. If the commission does not issue a declaratory ruling within one hundred eighty days after filing of a request or within such longer period as may be agreed by the parties, the commission shall be deemed to have decided not to issue such ruling.

(d) **Notice of decision.** A copy of all rulings issued and any actions taken under subsection (c) of this section shall be promptly delivered to the petitioner and other parties

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personally or by United States mail, certified or registered, postage prepaid, return receipt requested.

(Effective June 23, 1986; Amended September 3, 1998; Amended February 2, 2004)

Sec. 19a-401-19. Place of hearing

Hearings shall be held at times and locations specified by the Chairman of the Commission on Medicolegal Investigations pursuant to Statute.

(Effective June 23, 1986; Amended September 3, 1998)

Sec. 19a-401-20. Hearings

(a) **Persons notified.** The Chairman of the Commission on Medicolegal Investigations shall give written notice of a hearing to all parties and to such other persons as have filed with the Chairman their written request to be notified of a hearing in the particular matter and to such additional persons as the Chairman deems appropriate and advisable. The Chairman shall give such notice by newspaper publication as may be required by law.

(b) **Contents of notice.** Notice of a hearing shall include but shall not be limited to the following: (1) a statement of the time, place and nature of the hearing; (2) a statement of the legal authority and jurisdiction under which the hearing is to be held; (3) a reference to the particular sections of the statutes and regulations involved; (4) a short and plain statement of fact describing the matters asserted.

(c) If a hearing is held, the contested case provisions of the Uniform Administrative Procedure Act shall apply.

(Effective June 23, 1986; Amended September 3, 1998; Amended February 2, 2004)

Sec. 19a-401-21. Designation of hearing officer

The Chairman of the Commission on Medicolegal Investigations shall designate himself or such member as he deems appropriate to serve as the Hearing Officer.

(Effective June 23, 1986; Amended September 3, 1998)

Sec. 19a-401-22. Representation of parties

Each party and intervenor or their duly authorized representative shall file a written notice of appearance with the Hearing Officer prior to the commencement of the hearing.

(Effective June 23, 1986; Amended September 3, 1998; Amended February 2, 2004)

Sec. 19a-401-23. Repealed

Repealed February 2, 2004.

Sec. 19a-401-24. Purpose of hearing

The purpose of the hearing on a request for a declaratory ruling shall be to provide to all parties the opportunity to present evidence and argument on all issues to be considered by

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the Commission on Medicolegal Investigations.

(Effective June 23, 1986; Amended September 3, 1998; Amended February 2, 2004)

Sec. 19a-401-25. Order of procedure

The order of procedure shall be determined by the hearing officer and furnished to the parties at the beginning of the hearing. A transcript of the hearing shall be taken by a public stenographer and be presented to the members of the Commission along with the findings of the Hearing Officer.

(Effective June 23, 1986; Amended September 3, 1998; Amended February 2, 2004)

Sec. 19a-401-26. Limiting number of witnesses

The Hearing Officer may limit the number of witnesses or the time for testimony on any particular issue in the course of any hearing.

(Effective June 23, 1986; Amended September 3, 1998; Amended February 2, 2004)

Sec. 19a-401-27. Final decision

The Hearing Officer shall present his findings and furnish the full Commission with a final transcript of the hearing prior to the next scheduled meeting or sooner, as deemed appropriate. The findings of the Hearing Officer shall include all findings of the Hearing Officer which include all findings of fact and conclusions relied upon in arriving at his decision.

(Effective June 23, 1986; Amended September 3, 1998; Amended February 2, 2004)

Sec. 19a-401-28. Personal data

(a) The following definitions shall apply to sections 19a-401-28 to 19a-401-32, inclusive:

(1) "Category of Personal Data" means the classifications of personal information set forth in the Personal Data Act, Connecticut General Statutes section 4-190 (9).

(2) "Commission" means the Commission on Medicolegal Investigations.

(3) "Office" means the Office of the Chief Medical Examiner.

(4) "Other Data" means any information that because of name, identification number, mark or description can be readily associated with a particular person.

(5) "Personal Data Act" means the provisions of Chapter 55 of the Connecticut General Statutes.

(6) "State Personnel Act" means the provisions of Chapter 67 of the Connecticut General Statutes.

(b) Definitions contained in Connecticut General Statutes section 4-190 shall apply to sections 19a-401-28 to 19a-401-32, inclusive.

(Adopted effective February 2, 2004)

Sec. 19a-401-29. General nature and purpose of personal data

The Office of the Chief Medical Examiner maintains the following personal data systems:

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(a) Personnel records

(1) Personnel records for Office employees are maintained at 11 Shuttle Rd., Farmington, CT 06032.

(2) Personnel records are maintained in automated and manual form.

(3) The purpose of the system is to provide data necessary for personnel and payroll management activities as required by federal and state law.

(4) Personnel records are the responsibility of the Personnel Officer. The Personnel Officer, 11 Shuttle Rd., Farmington, CT 06032, oversees personnel systems. All requests for disclosure or amendment of these records should be directed to the Personnel Officer, Office of the Chief Medical Examiner, 11 Shuttle Rd., Farmington, CT 06032.

(5) Routine sources of information contained in personnel records include the employee, previous employers of the employee, references provided by the applicant, the employee's supervisor, the Comptroller's Office, the Department of Administrative Services, Division of Personnel, the Office of Labor Relations and insurance carriers.

(6) Categories of personal data maintained in personnel files may include, but are not necessarily limited to:

(A) payroll information such as longevity payments, designation of compensation plan, rate of pay, salary history, deductions;

(B) employment information such as starting date, title of position, employee transfer and termination information, performance appraisal, and records of disciplinary action;

(C) educational credentials;

(D) medical or emotional condition or history; and

(E) reputation and character.

(7) Categories of other data include name, address, telephone number, employee number, social security number, date of birth, designation of status as veteran, racial, ethnic and handicapped designation as appropriate, and general correspondence related to personnel matters such as requests for employment verification.

(8) The personnel department and other administrative or supervisory staff use personnel records as required to record and document the performance of personnel and payroll management activities within the Office.

(9) Personnel records are maintained on all classified and unclassified employees of the Office and on applicants for employment.

(10) Personal data in personnel records are collected, maintained and used under the authority of the State Personnel Act.

(b) Payroll records

(1) Payroll records for all Office employees are maintained in the Fiscal Office in the Office of the Chief Medical Examiner, 11 Shuttle Rd., Farmington, CT 06032. These records are the responsibility of the Office Business Manager. All requests for disclosure or amendment of these records should be directed to the Personnel Officer, Office of the Chief Medical Examiner, 11 Shuttle Rd., Farmington, CT 06032.

(2) Payroll records are maintained in automated and manual form.

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(3) The purpose of the system is to facilitate the Office's activities regarding payroll, budgeting, cost accounting, personnel planning and compliance with state and federal reporting requirements. Records are maintained for all current and former Office employees. Payroll records are used by the Fiscal Office staff to plan payroll and calculate budgets; to process promotions, reclassifications, transfers to other state agencies and retirements; and to maintain personnel documents required by, but not necessarily limited to the Comptroller's Office, Department of Administrative Services and group insurance carriers.

(4) Routine sources of information in payroll records may include the employee, the employee's supervisor, attendance sheets, contracts, the Comptroller's Office, the Department of Administrative Services, the Office of Labor Relations and insurance carriers.

(5) Categories of personal data maintained in payroll files may include:

(A) financial information such as salary records, longevity payments, compensation plan, rate of pay, deductions, salary history and garnishment of wages and payments related to garnishment; and

(B) employment information such as starting date, job classification and bargaining unit, attendance information, vacation, sick and personal leave days accrued and used, title of position, and contracts.

(6) Categories of other data may include name, address, social security number, date of birth, telephone number, marital status, insurance and retirement information, military service, and correspondence regarding payroll and benefits matters.

(7) Payroll data are collected, maintained and used under authority of the State Personnel Act.

(c) Client Records

(1) All client records are either located at the Office of the Chief Medical Examiner, 11 Shuttle Rd., Farmington, CT 06032 or at a records storage facility. Documents regarding the storage facility location and the records kept at such facility are located in Office of the Chief Medical Examiner, 11 Shuttle Rd., Farmington, CT 06032, in the custody of the Chief Medical Examiner.

(2) Records are maintained in automated and manual form.

(3) Client records are the responsibility of the Chief Medical Examiner or his designee. All requests for the disclosure or amendment of the records should be directed to the Chief Medical Examiner, or his designee.

(4) Routine sources of data may include interviews, examination of the client, information provided by family members, public and private health care providers, social workers, other professionals and other state agencies.

(5) Categories of personal data maintained in client records may include, but are not necessarily limited to:

(A) medical condition and history which includes the use of alcohol or other drugs;

(B) psychiatric and psychological condition and history;

(C) family and personal relationships;

(D) legal status, including relevant legal documents;

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(E) employment information such as employment status, education, occupation, and employer and income;

(F) treatment and discharge information, including treatment plans, physicians, orders, laboratory test results, progress notes, discharge plan, nature of the discharge, and referrals.

(6) Categories of other data include name, address, telephone number, date of birth, sex, racial or ethnic designation, social security number, and insurance information such as primary and secondary source, and type of insurance;

(7) Records are used by the individual hospital staff to reflect treatment planning and services provided to or on behalf of clients and their families.

(Adopted effective February 2, 2004)

Sec. 19a-401-30. Maintenance of personal data

(a) Personal data shall not be maintained unless relevant and necessary to accomplish the lawful purposes of the Office. Where the Office finds irrelevant or unnecessary public records in its possession, the Office shall dispose of the records in accordance with its record retention schedule and with the approval of the Public Records Administrator as per section 11-8a of the Connecticut General Statutes, or, if the records are not disposable under the records retention schedule, request permission from the Public Records Administrator to dispose of the records under section 11-8a of the Connecticut General Statutes.

(b) The Office shall collect and maintain all records with accurateness and completeness.

(c) Office employees involved in the operations of the Office's personal data systems shall be informed of the provisions of: (1) the Personal Data Act; (2) the commission's regulations adopted pursuant to section 4-196 of the Connecticut General Statutes; (3) the Freedom of Information Act and (4) any other state or federal statute or regulations concerning maintenance or disclosure of personal data kept by the Office.

(d) All Office employees shall take reasonable precautions to protect personal data under their custody from the danger of fire, theft, flood, natural disasters and other physical threats.

(e) The Office shall incorporate by reference the provisions of the Personal Data Act and regulations promulgated thereunder in all contracts, agreements or licenses for operation of a personal data system or for research, evaluation and reporting of personal data for the Office or on its behalf.

(f) The Office shall insure that personal data requested and received from any other agency is maintained in conformance with the Personal Data Act.

(g) Only Office employees who have a specific need to review personal data records for lawful purposes of the Office shall be entitled to access to such records under the Personal Data Act.

(h) The Office shall insure that all records in manual personal data systems are kept under lock and key and, to the greatest extent practical, are kept in controlled access areas.

(i) With respect to automated personal data systems, the Office shall:

(1) to the greatest extent practical, locate automated equipment and records in a limited access area;

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(2) to the greatest extent practical, require visitors to such area to sign a visitor's log and permit access to said area on a bona-fide need-to-enter basis only;

(3) to the greatest extent practical, insure that regular access to automated equipment is limited to operations personnel;

(4) utilize appropriate access control mechanisms to prevent disclosure of personal data to unauthorized individuals.

(j) Records for each personal data system are maintained in accordance with schedules prepared by the Connecticut State Library, Department of Public Records Administration and records retention schedule as approved by the Public Records Administrator as authorized by section 11-8a of the Connecticut General Statutes. Retention schedules shall be maintained on file at the Office and may be examined during normal business hours.

(Adopted effective February 2, 2004)

Sec. 19a-401-31. Disclosure of personal data

(a) The Office shall not disclose to the public personal records of a confidential or private nature except as required under state and federal law.

(b) Within four business days of receipt of a written request therefore, the Office shall mail or deliver to the requesting individual a written response in plain language, informing him or her as to whether or not the Office maintains personal data on that individual, the category and location of the personal data maintained on that individual and procedures available to review the records.

(c) Except where non-disclosure is required or specifically permitted by law, the Office shall disclose to any person upon written request all personal data concerning that individual which is maintained by the Office. The procedures for disclosure shall be in accordance with the Freedom of Information Act, as defined in section 1-200 of the Connecticut General Statutes. If the personal data is maintained in coded form, the Office shall transcribe the data into commonly understandable form before disclosure.

(Adopted effective February 2, 2004)

Sec. 19a-401-32. Contesting the content of personal data records

(a) Any person who believes that the Office is maintaining inaccurate, incomplete or irrelevant personal data concerning him or her may file a written request with the official of the Office who is responsible for maintaining such records for correction of said personal data.

(b) Within thirty (30) days of receipt of such request, the official of the Office who is responsible for maintaining the records shall give written notice to that person that the Office will make the requested correction, or if the correction is not to be made as submitted, the official of the Office shall state the reason for the Office's denial of such request and notify the person of his or her right to add his or her own statement to his or her personal data records.

(c) Following such denial by the Office, the person requesting such correction shall be

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permitted to add a statement to his or her personal data records setting forth what that person believes to be an accurate, complete and relevant version of the personal data in question. Such statements shall become a permanent part of the Office's personal data system and shall be disclosed to any individual, agency or organization to which the disputed data is disclosed.

(Adopted effective February 2, 2004)

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Agency

Office of the Chief Medical Examiner

Subject

Fees To Be Charged for the Services of the Chief Medical Examiner and the Professional Staff of the Office of the Chief Medical Examiner As Experts

Section

§ 19a-403-1

CONTENTS

Sec. 19a-403-1.	Fees to be charged for the services of the Chief Medical Examiner and the professional staff of the Office of the Chief Medical Examiner as experts in matters concerning deaths investigated by the office
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Fees To Be Charged for the Services of the Chief Medical Examiner and the Professional Staff of the Office of the Chief Medical Examiner As Experts

Sec. 19a-403-1. Fees to be charged for the services of the Chief Medical Examiner and the professional staff of the Office of the Chief Medical Examiner as experts in matters concerning deaths investigated by the office

(a) **Definitions.** As used in this section:

(1) “Consultation” means a conference at which advice is given or views are exchanged;

(2) “Consultation Services” means services performed with a view to rendering expert advice in a case;

(3) “Office” means the Office of the Chief Medical Examiner;

(4) “Party” means a person admitted or named as a party in a court case or an administrative proceeding;

(5) “Professional Staff of the Office of the Chief Medical Examiner” means the Deputy Chief Medical Examiner, Associate Medical Examiners, the Director of the Office of the Chief Medical Examiner toxicology laboratory, and any other full time employees of the Office whose job description includes giving expert testimony. The term does not apply to Assistant Medical Examiners or consultants the Office retains; and

(6) “Testimony” means expert testimony as well as testimony as to facts witnessed.

(b) **Criminal Cases.** The Chief Medical Examiner and the professional staff of the Office of the Chief Medical Examiner shall, without charge to the parties, testify in court in criminal cases brought in the courts of this state or in federal courts. They shall also provide free consultation services to the parties in such cases. They may testify free of charge and provide free consultation services in criminal cases brought in the courts of other states. When testimony or consultation services in cases in jurisdictions outside Connecticut require travel out of state, the party requesting the testimony or services shall bear the cost of such travel. The party requesting the testimony or services shall also bear the necessary cost of lodging and meals associated with such travel.

(c) **Civil Cases.**

(1) The per diem rate for the courtroom appearance of the Chief Medical Examiner or a member of the professional staff of the Office is five hundred dollars (\$500.00). The per diem rate for the appearance of the Chief Medical Examiner or a member of the professional staff of the office at a hearing before a tribunal such as a magistrate, hearing officer, board or commission is five hundred dollars (\$500.00). These fees do not apply to the State of Connecticut or any of its agencies or any of its employees acting in an official capacity. If the Chief Medical Examiner or a member of the professional staff of the Office travels to the court or the venue of a hearing at the request of the party calling him but does not testify, such party is still liable for the per diem rate.

(2) The compensation of the Chief Medical Examiner or a member of the professional staff of the Office for travel, meal and lodging expenses is the responsibility of the party that calls him. If the Chief Medical Examiner or such member of the professional staff of the Office travels to court or a hearing venue in his own vehicle he shall receive from the

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party that called him mileage expenses at a per mile rate equal to that payable by the State of Connecticut.

(d) **Depositions or affidavits in Civil Matters.** Whenever the Chief Medical Examiner or a member of the professional staff is called to testify in a civil deposition or to prepare an affidavit, the party calling the deposition or requesting the affidavit shall compensate the State of Connecticut for the time of the Chief Medical Examiner or a member of the professional staff of the Office at the rate of one hundred twenty-five dollars (\$125.00) per hour. The rate for the proofreading of the deposition transcript or affidavit and the completion of an errata sheet by the Chief Medical Examiner or a member of the professional staff of the Office is one hundred twenty-five dollars (\$125.00) per hour. The party calling the deposition or requesting the affidavit is responsible for paying these fees. The State of Connecticut, its agencies and its employees acting in their official capacity are exempt from paying these fees.

(e) **Compensation for Consultation Services.** If counsel for parties involved in a civil action seeks consultation with the Chief Medical Examiner or a member of the professional staff of the Office, such counsel shall compensate the State of Connecticut for time spent in consultation in excess of two (2) hours at the rate of one hundred twenty-five dollars (\$125.00) an hour. Such consultation shall be at the discretion of the Chief Medical Examiner. This rate does not apply to anybody serving as counsel for the State of Connecticut, its agencies or employees acting in their official capacity.

(f) **Actions for Failure to Pay for Services Rendered.** Failure to pay for services rendered under the provisions of this section shall subject the party failing to pay for services rendered to a lawsuit by the State of Connecticut. The Office may also initiate grievance proceedings before the Statewide Grievance Committee against the lawyer or lawyers involved.

(Adopted effective May 25, 1999)

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Agency

Department of Mental Retardation

Subject

Administration of Medication in Day and Residential Programs and Facilities Operated, Licensed or Funded by the Department of Mental Retardation

Inclusive Sections

§§ 19a-460-1—19a-460-10

CONTENTS

Sec. 19a-460-1—19a-460-10. Transferred

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Department of Mental Retardation

§

Administration of Medication in Day and Residential Programs and Facilities Operated, Licensed or Funded by the Department of Mental Retardation

Sec. 19a-460-1—19a-460-10. Transferred

Transferred, August 24, 1994.

Existing Section

New Section

19a-460-1	17a-210-1
19a-460-2	17a-210-2
19a-460-3	17a-210-3
19a-460-4	17a-210-4
19a-460-5	17a-210-5
19a-460-6	17a-210-6
19a-460-7	17a-210-7
19a-460-8	17a-210-8
19a-460-9	17a-210-9
19a-460-10	17a-210-10

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Agency

Department of Mental Retardation

Subject

**Community Based Housing Subsidy Program for Eligible Clients of the Department
of Mental Retardation**

Inclusive Sections

§§ 19a-464a-1—19a-464a-17

CONTENTS

Sec. 19a-464a-1—19a-464a-7.	Transferred
	Respite Program
Sec. 19a-464a-8—19a-464a-17.	Transferred

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Department of Mental Retardation

§

Community Based Housing Subsidy Program for Eligible Clients of the Department of Mental Retardation

Sec. 19a-464a-1—19a-464a-7. Transferred

Transferred, August 24, 1994.

<i>Existing Section</i>	<i>New Section</i>
19a-464a-1	17a-218- 1
19a-464a-2	17a-218- 2
19a-464a-3	17a-218- 3
19a-464a-4	17a-218- 4
19a-464a-5	17a-218- 5
19a-464a-6	17a-218- 6
19a-464a-7	17a-218- 7

Respite Program

Sec. 19a-464a-8—19a-464a-17. Transferred

Transferred, August 24, 1994.

<i>Existing Section</i>	<i>New Section</i>
19a-464a-8	17a-218- 8
19a-464a-9	17a-218- 9
19a-464a-10	17a-218-10
19a-464a-11	17a-218-11
19a-464a-12	17a-218-12
19a-464a-13	17a-218-13
19a-464a-14	17a-218-14
19a-464a-15	17a-218-15
19a-464a-16	17a-218-16
19a-464a-17	17a-218-17

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Agency

Department of Mental Retardation

Subject

Licensure of Private Residential Facilities for Mentally Retarded and Autistic People

Inclusive Sections

§§ 19a-467-1—19a-467-33

CONTENTS

Part 1

Licensure of Private Dwellings as Community Training Homes for Mentally Retarded and Autistic Persons

Sec. 19a-467-1—19a-467-8. Repealed

Community Training Home Licensing Regulations

Sec. 19a-467-1a—19a-467-8a. Transferred

Part II

Licensure of Private Facilities as Group Homes, Community Living Arrangements, Group Residences, Residential Schools, and Habilitative Nursing Facilities for Mentally Retarded and Autistic Persons

Sec. 19a-467-9—19a-467-26. Repealed

Contracting for Residential Support Services Supported Living Services

Sec. 19a-467-27—19a-467-33. Transferred

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Department of Mental Retardation

§19a-467-27—19a-467-33

Licensure of Private Residential Facilities for Mentally Retarded and Autistic People

Part 1

Licensure of Private Dwellings as Community Training Homes for Mentally Retarded and Autistic Persons

Sec. 19a-467-1—19a-467-8. Repealed

Repealed January 1, 1990.

Community Training Home Licensing Regulations

Sec. 19a-467-1a—19a-467-8a. Transferred

Transferred, August 24, 1994.

Existing Section

New Section

19a-467-1a

17a-227-23

19a-467-2a

17a-227-24

19a-467-3a

17a-227-25

19a-467-4a

17a-227-26

19a-467-5a

17a-227-27

19a-467-6a

17a-227-28

19a-467-7a

17a-227-29

19a-467-8a

17a-227-30

Part II

Licensure of Private Facilities as Group Homes, Community Living Arrangements, Group Residences, Residential Schools, and Habilitative Nursing Facilities for Mentally Retarded and Autistic Persons

Sec. 19a-467-9—19a-467-26. Repealed

Repealed October 1, 1992.

Contracting for Residential Support Services Supported Living Services

Sec. 19a-467-27—19a-467-33. Transferred

Transferred, August 24, 1994.

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Existing Section

New Section

19a-467-27

17a-227-31

19a-467-28

17a-227-32

19a-467-29

17a-227-33

19a-467-30

17a-227-34

19a-467-31

17a-227-35

19a-467-32

17a-227-36

19a-467-33

17a-227-37

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Subject

Community Work Services Program

Inclusive Sections

§§ 19a-482-1—19a-482-5

CONTENTS

Sec. 19a-482-1—19a-482-5. Repealed

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Community Work Services Program

Sec. 19a-482-1—19a-482-5. Repealed

Repealed March 26, 1991.

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Department of Mental Retardation

Subject

Funding Program for Privately Operated Community Residences for Mentally Retarded Persons

Inclusive Sections

§§ 19a-483b-1—19a-483b-15

CONTENTS

Sec. 19a-483b-1—19a-483b-15. Transferred

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Department of Mental Retardation

§

Funding Program for Privately Operated Community Residences for Mentally Retarded Persons

Sec. 19a-483b-1—19a-483b-15. Transferred

Transferred, June 28, 1994.

<i>Existing Section</i>	<i>New Section</i>
19a-483b-1	17a-230-1
19a-483b-2	17a-230-2
19a-483b-3	17a-230-3
19a-483b-4	17a-230-4
19a-483b-5	17a-230-5
19a-483b-6	17a-230-6
19a-483b-7	17a-230-7
19a-483b-8	17a-230-8
19a-483b-9	17a-230-9
19a-483b-10	17a-230-10
19a-483b-11	17a-230-11
19a-483b-12	17a-230-12
19a-483b-13	17a-230-13
19a-483b-14	17a-230-14
19a-483b-15	17a-230-15

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Subject

Work Incentive Grants for Certain Fully Employed Residents of Community Facilities

Inclusive Sections

§§ 19a-483c-1—19a-483c-4

CONTENTS

Sec. 19a-483c-1—19a-483c-4. Repealed

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§

Work Incentive Grants for Certain Fully Employed Residents of Community Facilities

Sec. 19a-483c-1—19a-483c-4. Repealed

Repealed November 17, 1994.

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Subject

Mobile Field Hospital

Section

§ 19a-487b-1

CONTENTS

Sec. 19a-487b-1. Mobile field hospital

Mobile Field Hospital

Sec. 19a-487b-1. Mobile field hospital

(a) Administration

(1) A hospital, as defined in section 19a-490(b) of the general statutes, may operate a mobile field hospital, as defined in section 19a-487(a) of the general statutes, only if the Governor or the Governor's designee has authorized the activation of the mobile field hospital and only if the Department of Public Health has determined that the requirements specified below have been satisfied:

(A) The hospital has completed a site assessment and identified a suitable location to place the mobile field hospital and the department has approved of this location; and

(B) The hospital has developed or adopted policies and protocols governing the operation of the mobile field hospital including, but not limited to, procedures for credentialing and staffing of the mobile field hospital disaster response and isolation care.

(2) The hospital shall be responsible for operation of the mobile field hospital with logistical support from the department.

(b) Medical staff

(1) The medical staff of the mobile field hospital shall be under the supervision of a physician who has been designated as the medical director by the hospital for the incident for which the mobile field hospital has been activated.

(2) Said physician shall:

(A) Have a valid and current Connecticut license;

(B) Be qualified in the type of care and services being rendered;

(C) Be responsible for the quality of services being provided; and

(D) Have one (1) year of experience or training in supervising staff who are functioning in an emergent situation, or equivalent experience.

(c) Nursing services

(1) The nursing staff of the mobile field hospital shall be under the supervision of a registered nurse or advanced practice registered nurse designated as the nursing supervisor by the hospital for the incident for which the mobile field hospital has been activated.

(2) The nursing supervisor shall:

(A) Have a valid and current Connecticut license;

(B) Be responsible for the provision and quality of nursing services; and

(C) In consultation with the medical director physician, ensure sufficient nursing personnel are available to meet the needs of the patients.

(3) A registered nurse shall be on duty at all times the mobile field hospital is providing nursing services.

(d) Medical records

(1) A medical record shall be created for each patient at the time of admission to the mobile field hospital and shall include, but need not be limited to:

(A) Identification data; and

(B) A registered nurse or licensed practitioner's notation describing the patient's

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condition on admission.

(2) The medical record of each patient admitted to the mobile field hospital shall contain sufficient information to justify the necessity of treatment, isolation, or other intervention. All necessary physical, mental, or other health assessments shall be performed and recorded by a practitioner with applicable statutory authority to perform said assessments.

(3) Medical records shall be safeguarded against loss, destruction or unauthorized use. Electronic medical records shall be consistent with state and federal policies and procedures for interoperability, privacy and security. Entries in medical records shall be legible and shall be signed by the practitioner who made the entry, provided the service, or wrote the order.

(e) General

(1) The mobile field hospital shall maintain, or have available, appropriate equipment and sufficient qualified staff to meet the needs of the patients.

(2) The hospital may contract for services, in compliance with federal and state laws, that are necessary for the provision of patient care or mobile field hospital operations related to the incident for which the mobile field hospital has been activated. Such services may include, but are not limited to: pharmacy, radiology, dietary, laboratory, laundry, waste removal, and security.

(Effective September 10, 2012)

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Subject

Medical Protocol for the Administration of Influenza and Pneumococcal Polysaccharide Vaccines for Patients in Hospitals

Inclusive Sections

§§ 19a-490k-1—19a-490k-2

CONTENTS

Sec. 19a-490k-1.	Definitions
Sec. 19a-490k-2.	Procedures for the administration of influenza and pneumo-coccal polysaccharide vaccines in accordance with a physician approved hospital policy

Medical Protocol for the Administration of Influenza and Pneumococcal Polysaccharide Vaccines for Patients in Hospitals

Sec. 19a-490k-1. Definitions

As used in section 19a-490k-1 through 19a-490k-2, inclusive, of the Regulations of Connecticut State Agencies:

- (1) “Hospital” means any short-term hospital or long-term hospital, as defined in subsection (b) of section 19-13-D1 of the Regulations of Connecticut State Agencies;
- (2) “Medical protocol” means a set of predetermined criteria developed and adopted by the medical staff of the hospital for a specified medical regimen;
- (3) “Medical staff” means an organized group of physicians, licensed in Connecticut, one of whom serves as a chief or president of the medical staff, that have been appointed by the governing board of a hospital and are responsible for the quality of medical care provided to patients by the hospital; and,
- (4) “Physician-approved hospital policy” means a medical protocol that has been adopted by the medical staff and approved by the governing board of the hospital.

(Adopted effective October 28, 2005)

Sec. 19a-490k-2. Procedures for the administration of influenza and pneumo-coccal polysaccharide vaccines in accordance with a physician approved hospital policy

(a) A hospital may develop a physician-approved hospital policy for the administration of influenza and pneumococcal polysaccharide vaccines without written or verbal physician orders, and such policy shall be deemed to have the same force and effect as an individual physician order, provided:

- (1) The medical staff of the hospital develops and adopts such policy,
- (2) the medical staff reviews such policy annually, and
- (3) such policy includes, but is not limited to:
 - (A) A specified assessment of each patient that shall be documented in the patient’s medical record and shall include contraindications to the vaccinations, dosage, route of administration and site of vaccination;
 - (B) documentation in the medical record of any patient who refused the vaccination;
 - (C) recording of the vaccination in the patient’s medical record and on the patient discharge instructions or the inter-agency patient referral report; and,
 - (D) provisions for administering the vaccinations in accordance with the current recommendations of the Centers for Disease Control, as amended from time to time.
- (b) Implementation of a physician-approved hospital policy for influenza and pneumococcal polysaccharide vaccines shall include:
 - (1) In-service training of all licensed staff who will implement the physician-approved hospital policy; and,
 - (2) provisions for monitoring and evaluation of the policy.
- (c) Nothing in these regulations shall be construed to preclude an individual physician from writing an order exempting the physician’s patient from the administration of influenza

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or pneumococcal polysaccharide vaccines.

(Adopted effective October 28, 2005)

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Subject

Licensure of Private Freestanding Mental Health Day Treatment Facilities, Intermediate Treatment Facilities and Psychiatric Outpatient Clinics for Adults

Inclusive Sections

§§ 19a-495-1—19a-495-571

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Sec. 19a-495-5b.	Short-term hospitals, special, hospice
Sec. 19a-495-6.	Reserved
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Sec. 19a-495-6b.	Licensure procedures
Sec. 19a-495-6c.	Governing authority
Sec. 19a-495-6d.	Administration
Sec. 19a-495-6e.	General requirements
Sec. 19a-495-6f.	Hospice inpatient facility services
Sec. 19a-495-6g.	In-service training and education
Sec. 19a-495-6h.	Patient rights and hospice inpatient facility responsibilities
Sec. 19a-495-6i.	Quality assessment and performance improvement
Sec. 19a-495-6j.	Assessment and patient centered plan of care
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Sec. 19a-495-6l.	Medical supplies and durable equipment
Sec. 19a-495-6m.	Hospice inpatient facility physical plant
Sec. 19a-495-7—19a-495-499.	Reserved
Licensure of private freestanding mental health day treatment facilities, intermediate treatment facilities and psychiatric outpatient clinics for adults	
Sec. 19a-495-550.	Licensure of private freestanding mental health day treatment facilities, intermediate treatment facilities and psychiatric outpatient clinics for adults
Licensure of Private Freestanding Mental Health Residential Living Centers	
Sec. 19a-495-551.	Licensure of private freestanding mental health residential living centers

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Sec. 19a-495-552—19a-495-559. Reserved

Licensure of Private Freestanding Community Residences

Sec. 19a-495-560. Licensing of private freestanding community residences

Sec. 19a-495-561—19a-495-569. Reserved

Licensure of Private Freestanding Facilities for the Care or the Treatment of Substance Abusive or Dependent Persons

Sec. 19a-495-570. Licensure of private freestanding facilities for the care or the treatment of substance abusive or dependent persons

Licensure of Recovery Care Centers and Standards For In-hospital Recovery Care Centers

Sec. 19a-495-571. Licensure of recovery care centers and standards for In-Hospital Recovery Care Centers.

Licensure of Private Freestanding Mental Health Day Treatment Facilities, Intermediate Treatment Facilities and Psychiatric Outpatient Clinics for Adults

Sec. 19a-495-1—19a-495-5. Reserved

Short-term Hospitals, Special, Hospice and Hospice Inpatient Facilities

Sec. 19a-495-5a. Applicability

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

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

(Effective July 31, 2012)

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

(a) Physical plant:

(1) General

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

(B) Construction plans and specifications, as well as program details, shall be submitted

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to and approved by the Department of Public Health prior to the start of construction.

(C) The facilities and distinct hospice units shall be of sound construction.

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

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

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

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

(2) Site.

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

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

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

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

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

(6) Nursing unit.

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

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

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

(ii) Maximum room capacity shall be four patients;

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

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

(v) Each room shall be located on an outside wall of the facility or hospice unit;

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

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

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

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

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

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

(7) Service area requirements for each nursing unit shall provide:

(A) Storage space for office supplies;

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

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

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

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

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

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

(H) A drug distribution station with a locked room for the storage of drugs and biological products. The drug storage room shall be located so as to be under the visual control of the nursing or pharmacy staff. The drug storage and preparation area shall be of adequate size for proper storage, handling, preparation, and record keeping of all drugs and shall contain a work counter, refrigerator, hand sink with hot water, and necessary equipment such as a

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locked cabinet containers or drug carts;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(i) On-site processing requires the following:

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- (I) A laundry processing room with commercial-type equipment;
- (II) A soiled linen receiving, holding and sorting room with hand washing facilities;
- (III) Storage for laundry supplies;
- (IV) Deep sink for soaking clothes;
- (V) Clean linen storage, holding room and ironing area; and
- (VI) Janitor's closet containing a floor receptor or service sink and locked storage space for housekeeping equipment and supplies.
- (ii) Off-site processing requires the following:
 - (I) A soiled linen holding room with hand washing facilities; and
 - (II) A clean linen receiving, holding, inspection and storage room.
- (iii) Each facility shall have a domestic type washer and dryer, located in a separate room, for patients' personal use.
- (DD) A separate room or building for furnaces, boilers, electrical and mechanical equipment and building maintenance supplies;
- (EE) A separate toilet room for employees of each sex with one water closet and one lavatory for each twenty employees of each sex;
- (FF) Separate locker rooms for each sex containing individual lockers of adequate size for employee clothing and personal effects. The lockers shall be in an area divided from the water closets and lavatories; and
- (GG) Separate employee dining space in the ratio of fifteen square feet per employee dining at one time that shall not be included in the space requirement for any other area.
- (8) Construction requirements.
 - (A) Fixtures such as drinking fountains, telephone booths, vending machines, and portable equipment shall be located so as not to restrict corridor traffic or reduce the corridor width.
 - (B) Room's containing bathtubs, showers, and water closets, for use by patients, shall be equipped with doors and hardware that provide access from the outside in any emergency.
 - (C) The minimum width of all doors to rooms needing access for beds or stretchers shall be three feet, eight inches. Doors to patients' toilet rooms and other rooms needing access for wheelchairs shall have a minimum width of two feet, ten inches.
 - (D) Doors on all openings between corridors and rooms or spaces subject to occupancy, except elevator doors, shall be of the swing type. Openings to showers, baths, patient toilets and other small wet-type areas not subject to fire hazard are exempt from this requirement.
 - (E) Doors, except those to spaces such as small closets that are not subject to occupancy, shall not swing into corridors in a manner that might obstruct traffic flow or reduce the corridor width.
 - (F) Windows and outer doors shall be provided with insect screens. Windows shall either be designed to prevent accidental falls when they are open, or shall be provided with security screens.
 - (G) Dumbwaiters, conveyors, and material handling systems shall not open directly into a corridor or exitway but shall open into a room enclosed by construction having a fire-

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resistance of not less than two hours and provided with class B one and one-half hour labeled fire doors. Service entrance doors to vertical shafts containing dumbwaiters, conveyors, and material handling systems shall be not less than class B one and one-half hour labeled fire doors. Where horizontal conveyors and material handling systems penetrate fire-rated walls or smoke partitions, such openings shall be provided with class D one and one-half hour labeled fire doors for two hour walls.

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

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

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

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

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

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

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

(O) Ceiling heights shall be as follows:

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

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

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

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

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

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

(T) Elevators:

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

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

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

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

(9) Mechanical system requirements.

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

(B) Steam and hot water systems.

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

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

(C) Air conditioning, heating and ventilating systems.

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

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

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

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

TABLE I General Pressure Relationships and Ventilation Of Certain Hospice Areas

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

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Area Designation	Pressure Relationship to Adjacent Areas	Minimum Air Changes of Outdoor Air per Hour Supplied to Room	Minimum Total Air Changes Per Hour Supplied to Room	All Air Exhausted Directly to Outdoors	Recirculated Within Room units
Toilet Room	N	Optional	10	Yes	No
Bedpan Room	N	Optional	10	Yes	No
Bathroom	N	Optional	10	Yes	No
Janitor's closet	N	Optional	10	Yes	No
Sterilizer Equipment Room	N	Optional	10	Yes	No
Linen and Trash	N	Optional	10	Yes	No
P=Positive					
N=Negative					
E=Equal					

(D) Plumbing and other piping systems.

(i) Plumbing fixtures.

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

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

(ii) Water supply systems.

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

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

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

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

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(iii) Hot water heaters and tanks.

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

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

(E) Medical gas and vacuum systems.

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

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

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

(10) Electrical system requirements.

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

(B) Switchboards and power panels. Circuit breakers or fusible switches that provide disconnecting means and overcurrent protection for conductors connected to switchboard's and panelboards shall be enclosed or guarded to provide a dead-front type of assembly. The main switchboard shall be located in a separate enclosure accessible only to authorized persons. The switchboards shall be convenient for use, readily accessible for maintenance, clear of traffic lanes, and in a dry ventilated space free of corrosive fumes or gases. Overload protective devices shall be suitable for operating properly in the ambient temperature conditions.

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

(D) Lighting.

(i) All spaces occupied by people, machinery, and equipment within buildings,

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approaches to buildings, and parking lots shall have lighting.

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

(E) Receptacles or outlets.

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

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

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

(G) Emergency electric service.

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

(ii) The emergency generating set shall provide electricity:

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

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

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

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

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

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- (VI) To one duplex receptacle at each patient bed;
- (VII) To the nurses' calling system;
- (VIII) To operate equipment necessary for maintaining telephone service;
- (IX) To the fire pump, if any; and
- (X) To circuits that serve necessary equipment as follows:

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

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

(c) Central suction systems serving medical functions;

(d) Laboratory fume hoods.

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

(i) The emergency electrical system shall ensure that after interruption of the normal electric power supply the generator is brought to full voltage and frequency and connected within ten seconds through one or more primary automatic transfer switches to emergency lighting systems, alarm systems, blood banks, nurses' calling systems, equipment necessary for maintaining telephone service, and task illumination and receptacles in operating, delivery, emergency, recovery, and cardiac catheterization rooms, intensive care nursing areas, nurseries, and other critical patient areas. All other lighting and equipment required to be connected to the emergency system shall either be connected through the primary automatic transfer switches, as described in this subparagraph, or through other automatic or manual transfer switches. Receptacles connected to the emergency system shall be distinctively marked. Storage-battery-powered lights, provided to augment the emergency lighting or for continuity of lighting during the interim of transfer switching immediately following an interruption of the normal service supply, shall not be used as a substitute for the requirement of a generator. Where stored fuel is required for emergency generator operation, the storage capacity shall be sufficient for not less than forty-eight hour continuous operation. When the generator is operated by fuel which is normally piped underground to the site from a utility distribution system, fuel storage facilities on the site shall not be required.

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

(b) **Administration.**

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

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

(i) admission criteria defining eligibility for hospice services;

(ii) guidelines for community relations;

(iii) a patient bill of rights;

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

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

(I) the purpose of the hospice;

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(c) Medical staff.

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

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

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

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

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

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

(E) provision for monthly staff conferences unless clinical groups hold departmental or service conferences at least monthly, then general staff conferences shall be held at least four times each year, and each active staff member shall attend not less than ten departmental or general staff meetings or a combination thereof each year;

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

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

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

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

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

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

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and nursing.

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

(d) Medical records.

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

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

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

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

(5) The medical records shall be kept confidential and secured. Written consent of the patient or the patient's legally appointed representative shall be required for release of medical information except as provided in subsection (t) of this section.

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

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

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

(e) Nursing Service.

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

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

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

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

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

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

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

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

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

(6) Written nursing care and administrative policies and procedures shall be developed to provide the nursing staff with practical methods of meeting its responsibilities and achieving projected goals. Policies shall include, but not be limited to, the following:

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

(B) standardized procedures for evaluation and study;

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

(D) patient and family teaching programs;

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

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

(7) There shall be staff development programs and educational opportunities for nursing

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personnel that include orientation and in-service education.

(f) Pharmaceutical service.

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

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

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

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

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

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

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

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

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

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

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

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

(g) Social work service.

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

(2) The social work staff may include baccalaureate social workers with at least one year

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of social work experience in a health care setting.

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

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

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

(h) Pastoral care service.

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

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

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

(i) The arts.

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

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

(3) The director of the arts shall be considered a full-fledged member of the health care team, with participation in all staff meetings. Written policies for the arts shall be developed

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and reviewed at least annually. Adequate records relating to artistic services rendered shall be included in the patient's medical record.

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

(j) **Volunteer service.**

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

(2) The director shall:

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

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

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

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

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

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

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

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

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

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hospice-based home care programs.

(n) Dietary service.

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

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

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

(A) recording nutritional histories of in-patients;

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

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

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

(E) coordinating activities with the food service supervisor.

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

(o) Hospice-based home care program.

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

(2) An organizational structure designed to effectively implement the requirements as described in subdivision (1) of this subsection. The medical director and the director of patient care services shall be vested with the overall coordination of the hospice-based home care program. The hospice-based home care program shall have a supervisor who shall meet the requirements of subparagraphs (e)(2)(A) or (B) of this section.

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

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

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

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

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

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

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

(p) Infection control.

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

(2) The infection prevention, surveillance, and control program of each hospice shall be

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approved by the medical staff and adopted by the governing board. The program shall become part of the by-laws of the medical staff.

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

(4) The infection control committee shall:

(A) adopt working definitions of hospice-associated infections;

(B) develop standards for surveillance of incidents of hospice-related infection and conditions predisposing patients to infection;

(C) monitor and report infections in all patients, including patients in the home care program, and environmental conditions with infection potential;

(D) evaluate the potential for environmental infection, including identification whenever possible of hospice-associated infections and periodic review of the clinical use of antibiotics in patient care; and

(E) develop preventive measures including aseptic techniques, isolation policy, and a personnel health program.

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

(6) The infections control committee shall meet at least monthly and:

(A) review information obtained from day-to-day surveillance activities of the program;

(B) review and revise existing standards; and

(C) report to the medical director.

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

(q) **General.**

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

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

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

(4) When a patient ceases to breathe and has no detectable pulse or blood pressure, the body shall be moved to the bereavement room in the same institution pending completion of the medical certification portion of the death certificate by a person authorized to complete such medical certification in accordance with section 7-62b of the Connecticut General Statutes. The facility shall make available a room that shall provide for the dignified holding of the body of the deceased person where the body of the deceased person shall not

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be exposed to the view of patients or visitors, but where the family and friends of the deceased may view the body.

(r) **Out-patient services.**

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

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

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

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

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

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

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

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

(Effective July 31, 2012)

Sec. 19a-495-6. Reserved

Sec. 19a-495-6a. Hospice inpatient facilities

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

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

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

(3) "Bereavement" means the extended period of grief, which is usually thirteen months, preceding the death and following the death of a loved one, during which individuals

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experience, respond and adjust emotionally, physically, socially and spiritually to the loss of a loved one;

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

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

(6) “Commissioner” means the Commissioner of Public Health, or the commissioner’s designee;

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

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

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

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

(11) “Department” means the Department of Public Health;

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

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

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

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

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

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

(18) “Hospice inpatient facility” means a facility or hospice residence that provides palliative care for hospice patients requiring short-term, general inpatient care for pain and

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symptom management, end of life care or respite care and provides the services required pursuant to 19a-122b of the Connecticut General Statutes;

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

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

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

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

(23) “Licensee” means a person, group of persons, association, organization, institution, or agency, public or private that is licensed in accordance with section 19a-495-6b of the Regulations of Connecticut State Agencies;

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

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

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

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

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

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

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

(31) “Pharmacist” shall have the same meaning as provided in section 20-571 of the

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Connecticut General Statutes;

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

(33) “Physician” shall have the same meaning as provided in section 20-13a of the Connecticut General Statutes;

(34) “Physician assistant” shall have the same meaning as provided in section 20-12a of the Connecticut General Statutes;

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

(36) “Representative” means a designated member of the patient’s family or person legally authorized to act for the patient in the exercise of the patient’s rights in accordance with applicable law;

(37) “Restraint” means:

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

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

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

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

(40) “Speech and language therapy services” means services provided in accordance with accepted standards of practice and applicable law by a speech and language pathologist licensed under Chapter 399 of the Connecticut General Statutes;

(41) “Spiritual counseling” means the assessment and delivery of services in accordance with the patient and family’s beliefs;

(42) “Spiritual counselor” means a person who is ordained clergy (individual ordained for religious service), pastoral counselor or other person who can support the patient’s spiritual needs;

(43) “Statement of ownership and operation” means a written statement as to the legal

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owners of the premises and legal entity that operates the hospice inpatient facility to be licensed; and

(44) “Volunteer” means a person who receives no remuneration for services provided to the hospice inpatient facility.

(Effective July 31, 2012)

Sec. 19a-495-6b. Licensure procedures

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

(b) Application for initial or renewal licensure.

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

(2) The application shall be signed by the owner of the hospice inpatient facility or by a person duly authorized to act on behalf of owner of the facility and shall include responses to all the information required on the forms provided by the department. The application shall be signed under oath, the signature notarized and the application form shall cite the provisions of section 53a-157b of the Connecticut General Statutes.

(3) Application for the grant or renewal of a license to operate a hospice inpatient facility shall include the following information, if applicable:

- (A) Statement of ownership and operation;
- (B) Names and titles of professional and unlicensed direct care employees;
- (C) Signed acknowledgement of duties for the administrator, medical director, and director of nurses upon initial application only;
- (D) Patient capacity;
- (E) Total number of employees, by category;
- (F) Services provided;
- (G) Evidence of financial capacity;
- (H) Certificates of malpractice and public liability insurance; and
- (I) Local Fire Marshal’s biennial license;
- (J) Affidavits as described in section 19a-491a(a) of the Connecticut General Statutes;
- (K) Reports from criminal history and patient abuse background searches pursuant to section 19a-491c of the Connecticut General Statutes;
- (L) The licensing or renewal fee as provided in the Connecticut General Statutes; and

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(M) Such additional information as the Department may request.

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

(c) Issuance and renewal of license.

(1) The commissioner may, in the commissioner's discretion, deny an application for licensure or a renewal application for any of the following reasons:

(A) The license application or renewal application is not complete;

(B) The applicant's failure to comply with applicable federal, state and local laws;

(C) If the commissioner determines that any of the individuals identified in subsection (b)(3) of this section have been subject to any of the criminal, civil or administrative actions described in section 19a-491a(a) of the Connecticut General Statutes; or

(D) A material misstatement of fact is made on an initial or renewal application.

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

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

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

(5) Each license shall specify:

(A) The maximum licensed bed capacity; and

(B) The names of the administrator, medical director and director of nurses; and

(C) Any provisional waivers of the Regulations of Connecticut State Agencies that have been granted to the hospice inpatient facility.

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

(7) Change in status. Change in ownership, level of care, number of beds or location shall require a new license to be issued. The licensee shall notify the department in writing no later than ninety days prior to any such proposed change. For purposes of this subdivision, any change in the ownership of a hospice inpatient facility, owned by a person, group of persons, organization, institution or agency, public or private, partnership or association or the change in ownership or beneficial ownership of ten per cent or more of the stock of a corporation that owns, conducts, operates or maintains such hospice inpatient facility, shall be subject to prior approval of the department after a scheduled inspection of such hospice inpatient facility is conducted by the department, provided such approval shall be conditioned upon a showing by such hospice inpatient facility to the commissioner that it has complied with all regulatory requirements. Any such change in ownership or beneficial ownership resulting in a transfer to a person related by blood or marriage to such an owner or beneficial owner shall not be subject to prior approval of the department unless: (A)

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Ownership or beneficial ownership of ten per cent or more of the stock of a corporation, partnership or association that owns, conducts, operates or maintains more than one hospice inpatient facility is transferred; (B) ownership or beneficial ownership is transferred in more than one hospice inpatient facility; or (C) the hospice inpatient facility is the subject of a pending complaint, investigation or licensure action. If the hospice inpatient facility is not in compliance, the commissioner may require the new owner to sign a consent order providing reasonable assurances that the violations shall be corrected within a specified period of time. Notice of any such proposed change of ownership shall be given to the department at least ninety days prior to the effective date of such proposed change. For the purposes of this subdivision, “a person related by blood or marriage” means a parent, spouse, child, brother, sister, aunt, uncle, niece or nephew. For the purposes of this subdivision, a change in the legal form of the ownership entity, including, but not limited to, changes from a corporation to a limited liability company, a partnership to a limited liability partnership, a sole proprietorship to a corporation and similar changes, shall not be considered a change of ownership if the beneficial ownership remains unchanged and the owner provides such information regarding the change to the department as may be required by the department in order to properly identify the current status of ownership and beneficial ownership of the facility or institution. For the purposes of this subdivision, a public offering of the stock of any corporation that owns, conducts, operates or maintains any hospice inpatient facility shall not be considered a change in ownership or beneficial ownership of such hospice inpatient facility if the licensee and the officers and directors of such corporation remain unchanged, such public offering cannot result in an individual or entity owning ten per cent or more of the stock of such corporation, and the owner provides such information to the department as may be required by the department in order to properly identify the current status of ownership and beneficial ownership of the hospice inpatient facility.

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

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

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

(d) Waiver.

(1) The commissioner may waive provisions of these regulations if the commissioner determines that such waiver would not endanger the health, safety or welfare of any patient.

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The commissioner may impose conditions upon granting the waiver that assure the health, safety and welfare of patients, or may revoke the waiver upon a finding that the health, safety, or welfare of any patient has been jeopardized. The commissioner may grant a waiver for a specified period of time subject to renewal in the commissioner's discretion. The licensee may seek renewal of the waiver by submitting the required written documentation specified in subsection (d)(2) of this section.

(2) The licensee requesting a waiver shall do so in writing to the department. Such request shall include:

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

(3) In consideration of any request for waiver, the commissioner may consider:

- (A) The level of care provided;
- (B) The maximum patient capacity;
- (C) The impact of a waiver on care provided; and
- (D) Alternative policies or procedures proposed.

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

(Effective July 31, 2012)

Sec. 19a-495-6c. Governing authority

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

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

- (1) A mission statement and purpose of the hospice inpatient facility;
- (2) Delineation of the powers, duties and voting procedures of the governing authority, its officers and committees;
- (3) Qualifications for membership, method of selection and terms of office of members and chairpersons of committees;
- (4) A description of the authority delegated to the administrator;
- (5) The conflict of interest policy and procedures;
- (6) Scope of services offered;
- (7) Admission and discharge criteria;
- (8) Medical and dental supervision and plans of treatment;
- (9) Clinical records;

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- (10) Personnel qualifications;
 - (11) Annual review of personnel policies;
 - (12) Adoption of written policies assuring the protection of patients' rights and patient grievance procedures, a description of which shall be posted conspicuously in the hospice inpatient facility and distributed personally to each patient upon admission; and
 - (13) Determination of the frequency of meetings of the governing authority.
- (c) The bylaws or rules shall be available to all members of the governing authority and the administrator.
- (d) The governing authority shall:
- (1) Meet as frequently as necessary to fulfill its responsibilities;
 - (2) Provide a written agenda and minutes for each meeting;
 - (3) For each meeting, provide minutes that include, but are not limited to, the identity of those members in attendance, reports of the quality assessment and performance improvement program and any patient grievances. Such minutes shall be approved by the governing authority and dated and signed by the secretary; and
 - (4) Ensure that the agenda and minutes of any of its meetings or any of its committees are available at any time to the commissioner.
- (e) Other specific responsibilities of the governing authority shall include, but not be limited to:
- (1) Oversight of the management and operation of the hospice inpatient facility;
 - (2) Oversight of the financial viability and management of the hospice inpatient facility's fiscal affairs;
 - (3) Adoption and documented annual review of written bylaws and budget;
 - (4) Services provided by the hospice inpatient facility and the quality of care rendered to patients and their families;
 - (5) Provision of a safe physical plant equipped and staffed to maintain the hospice inpatient facility and services in accordance with any applicable local and state regulations and any federal regulations that may apply to federal programs in which the hospice inpatient facility participates;
 - (6) Appointment of a qualified administrator;
 - (7) Approval of the administrator's appointment of a medical director;
 - (8) Approval of an organizational chart that establishes clear lines of responsibility and authority in all matters relating to management and maintenance of the facility and patient care;
 - (9) Annual review and update of the operation and fiscal plan, including anticipated needs, income and expenses;
 - (10) Establish and maintain the quality assessment and performance improvement program including, but not limited to, the selection and appointment of a quality assessment and performance improvement advisory committee; review of issues, corrective actions and outcomes; and recommendations for improvement;
 - (11) Policy and program determination and delegation of authority to implement policies

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and programs. The establishment of such policies shall include, but not be limited to:

- (A) Responsibilities of the administrator and the medical director;
 - (B) Conflict of interest on the part of the governing authority, professional staff and employees;
 - (C) Services to be provided;
 - (D) Criteria for the selection, admission and transfer of terminally ill patients and families;
 - (E) Patient or family consent and involvement in the development of patient centered plan of care;
 - (F) Developing a support network when the family is not available and the patient needs and wants that support;
 - (G) Referrals and coordination with community and other health care facilities or agencies that shall include but not be limited to a mechanism for recording, transmitting and receiving information essential to the continuity of patient care. Such information shall include, but not be limited to:
 - (i) Patient identification data including name, address, age, gender, name of representative, and health insurance coverage;
 - (ii) Diagnosis and prognosis, medical status of patient, brief description of current illness, medical and nursing plans of care including information such as drugs and biological products, treatments, dietary needs, baseline laboratory data;
 - (iii) Functional status;
 - (iv) Special services such as physical therapy, occupational therapy, speech and language therapy, and any other therapy; and
 - (v) Psychosocial needs.
 - (H) Professional management responsibilities for contracted services;
 - (I) Reports of patient's condition and procedures for the transmission of such reports to the patient's physician;
 - (J) Provisions governing the relationship of the attending physician or the advanced practice registered nurse to the medical director, and the interdisciplinary team; and
 - (K) Such other matters, as may be relevant to the organization and operation of hospice care.
- (12) Ensure that any and all services provided by hospice inpatient facility volunteers and direct service staff are consistent with accepted standards of practice and applicable law;
- (13) Maintain an active quality assessment and performance improvement committee and provide any and all services offered in compliance with sections 19a-495-6a to 19a-495-6m, inclusive of the Regulations of Connecticut State Agencies; and
- (14) Compliance with any established hospice inpatient facility policy.
- (f) Failure of the administrator to implement the bylaws, rules, policies, or programs adopted by the governing authority shall be grounds for disciplinary action against the

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licensee under section 19a-494 of the Connecticut General Statutes.

(Effective July 31, 2012)

Sec. 19a-495-6d. Administration

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

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

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

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

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

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

(b) The administrator shall:

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

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

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

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

(5) Obtain a criminal history and patient abuse background search pursuant to section 19a-491c of the Connecticut General Statutes for all employees and volunteers that have direct patient contact or access to patient records within three months from the date of employment for all states the employee has lived or worked in for the past three years; and shall ensure all contractors obtain the same for staff providing direct patient services.

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

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

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

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- (B) Ensuring and maintaining quality standards of professional practice;
 - (C) Implementation of patient care policies;
 - (D) The achievement and maintenance of quality assurance of professional practices through a mechanism for the assessment of patient and family care outcomes;
 - (E) Ensuring completion of health care worker screening and immunization requirements;
 - (F) Certification of patients admitted to the program;
 - (G) Participation as a member of the interdisciplinary team, in the development, implementation and assessment of patient centered plans of care;
 - (H) Consulting with licensed independent professionals regarding patient care plans; and
 - (I) Identifying a designee who is a licensed independent practitioner. The designee shall assume the same responsibilities and obligations as the medical director when the medical director is temporarily not available.
- (2) The medical director shall be available for consultation on a twenty-four hour basis and shall be on site at the hospice inpatient facility a sufficient number of hours to meet the responsibilities described in subparagraphs (1) (A) to (1) (I), inclusive of this subsection.
- (d) The administrator shall appoint a full-time director of nurses who is licensed as a registered nurse and possesses a baccalaureate degree in nursing with coursework or experience in hospice care. The director of nurses shall have the following qualifications:
- (1) A master's degree from a program approved by the Commission on Collegiate Nursing Education or the American Public Health Association with not less than two years' full-time clinical experience or community health program; or
 - (2) Not less than three years of full-time clinical experience in nursing, at least two of which were in a hospice, home health agency or community health program.
- (e) The director of nurses shall be responsible for the overall hospice inpatient facility's nursing services, which shall include:
- (1) Coordination of professional and non-professional nursing services provided;
 - (2) Ensuring and maintaining quality standards of professional practice;
 - (3) Development and implementation of patient care policies;
 - (4) Participation in the development and implementation of the patient centered plans of care;
 - (5) Consulting with other interdisciplinary team members regarding patient care; and
 - (6) Development and implementation of the hospice inpatient facility infection control and hospice inpatient facility safety policies.
- (f) Except for a hospice inpatient facility with twelve licensed beds or less, the administrator shall not serve as the director of nurses.
- (g) There shall be a written agreement for the provision of services if provided by a contractor and not directly by the licensee. The Commissioner shall have access to the records of the contractor related to performance of the agreement and the provision of services. The agreement shall clearly delineate the responsibilities of the contractor and

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licensee and shall include but not be limited to the following provisions:

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

(2) A stipulation that the licensee is responsible for the admission of patients;

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

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

(5) Assurance of compliance with the patient care policies of the licensed licensee;

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

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

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

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

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

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

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

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

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

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

(2) Started at the time of admission with identification, date, and a nurse's notation of condition on admission. Within twenty-four hours of admission, the attending practitioner shall add an admission note and orders. The attending practitioner shall record the patient's complete history and physical examination within twenty-four hours of admission, unless the patient's primary provider performed the patient's last history and physical examination within the last thirty days and is following the patient. In such case, the patient's last history and physical examination shall be noted in the medical record and a copy of that history

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and physical examination shall become part of the medical record.

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

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

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

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

(Effective July 31, 2012)

Sec. 19a-495-6e. General requirements

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

- (1) Services of a physician or advanced practice registered nurse;
- (2) Nursing services provided by a registered nurse, or licensed practical nurse;
- (3) Social services;
- (4) Counseling services if required;
- (5) Pain assessment and management; and
- (6) Availability of drugs and biological products on a twenty-four hour basis.

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

- (1) A criminal history and patient abuse background search pursuant to section 19a-491c of the Connecticut General Statutes including, but not limited to, all hospice inpatient facility employees or contracted employees and volunteers who have direct patient contact or access to patient records;
- (2) Mechanisms for the collaboration and coordination of care; and
- (3) The exchange of information to meet the ongoing needs of the patient and family;

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(c) In addition to the core services, the licensee shall ensure that the following services are provided, as needed, directly by the licensee or by a contractor under written agreement with the licensee:

- (1) Home health aide and homemaker services;
- (2) Short-term respite care and general inpatient care;
- (3) Physical therapy, occupational therapy, and speech and language pathology services;
- (4) Medical supplies and appliances;
- (5) Nutrition counseling;
- (6) Complementary therapies; and
- (7) Any other services identified in the patient centered plan of care.

(d) The licensee shall make services available as follows:

(1) Nursing services, physician services, drugs and biological products continuously available on a twenty-four hour basis;

(2) All other services available on a twenty-four hour basis to the extent necessary and reasonable to meet the needs of the patient care for the palliation and management of the patient's terminal illness and related conditions in accordance with the patient centered plan of care;

(3) Assessment capability available on a twenty-four hour basis to respond to acute and urgent patient or family needs; and

(4) Additional health services or related services may be provided as deemed appropriate to meet the patient's and family's needs, and all services shall be rendered in a manner consistent with accepted standards of practice and applicable law.

(e) The licensee shall ensure patient accessibility to the following:

(1) A functioning system that enables inpatients or outpatients and their families to make telephone contact with hospice inpatient facility staff on a twenty-four hour basis. Mechanical answering devices shall not be acceptable;

(2) A system that provides twenty-four hour, pharmacy services for the palliative care and management of the patient; and

(3) A system that ensures that patients are permitted to receive visitors, including small children and pets, at any hour, provided that a therapeutic environment is maintained.

(f) The licensee shall ensure the continuity of patient and family care through adoption and implementation of written policies, procedures and criteria providing for the following:

(1) Coordination of community physicians and nurses with hospice inpatient facility staff prior to and at the time of admission;

(2) Admission criteria for the initial assessment of the patient or family needs and decision for care;

(3) Signed informed consent;

(4) Ongoing assessment of the patient's and family's needs;

(5) Development and review of the patient centered plan of care by the interdisciplinary team;

(6) Transfer of patients to inpatient care facilities for inpatient respite care or general

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inpatient care;

(7) The provision of appropriate patient and family information at the point of transfer between care settings;

(8) Community or other resources to ensure continuity of care and to meet patient and family needs;

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

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

(Effective July 31, 2012)

Sec. 19a-495-6f. Hospice inpatient facility services

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

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

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

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

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

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

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

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

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

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

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

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

(A) Personal care;

(B) Ambulation and exercise;

(C) Assisting a patient with eating;

(D) Reporting changes in a patient's condition and needs;

(E) Completing a patient's medical records as directed; and

(F) Assisting with the patient's self-administration of drugs and biological products by:

(i) Reminding a patient to self-administer the drugs or biological products;

(ii) Verifying that a patient has self-administered their drugs or biological products;

(iii) Opening bottles, bubble packs or other forms of packaging if the patient is not capable of performing this function.

(8) Nursing services shall be provided under the direction of a licensed registered nurse to meet the nursing care needs of the patient and family, as identified in the patient centered plan of care. Nursing services shall be provided in accordance with accepted standards of practice, applicable law and hospice inpatient facility policies. There shall be a registered nurse on the premises on a twenty-four hour basis and there shall be a sufficient number of nursing personnel on a twenty-four hour basis to:

(A) Assess patients' needs;

(B) Assist in the development and implementation of patient centered plans of care;

(C) Provide direct patient care services; and

(D) Coordinate or perform other related activities to maintain the health and safety of the patients.

(9) Pharmacy services shall be provided under the direction of a licensed pharmacist who is an employee of or has a written agreement with the hospice inpatient facility. Duties of the pharmacist shall include, but not be limited to the following:

(A) Identification of potential adverse drug reactions, and recommended appropriate corrective action;

(B) Compounding, packaging, labeling, dispensing, and distributing all drugs to be administered to patients;

(C) Monitoring patient drug therapy for potential drug interactions and incompatibilities at least monthly with documentation of same;

(D) Inspecting all areas within the facility where drugs (including emergency supplies)

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are stored at least monthly to assure that all drugs are properly labeled, stored and controlled; and

(E) Serving as a consultant to the interdisciplinary team for pain control and symptom management.

(10) Spiritual counseling services shall be provided in accordance with the wishes of the patient as noted in the patient centered plan of care. Services may include, but not be limited to:

(A) Communication and support from a spiritual counselor;

(B) Consultation and education for the patient, family and interdisciplinary team members.

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

(A) Comprehensive evaluation of the psychosocial status of the patient and family as it relates to the patient's illness and environment;

(B) Counseling of the patient, family and primary caregivers;

(C) Participation in development of the patient centered plan of care; and

(D) Participation in ongoing case management with the hospice inpatient facility interdisciplinary team.

(12) Volunteer Services shall be provided under the supervision of designated hospice inpatient facility employees.

(A) Volunteers may provide administrative services or non-direct patient care services under the supervision of designated hospice inpatient facility employees;

(B) Direct patient care services may be provided by licensed or registered volunteers who meet the requirements for the provision of such services, under the supervision of appropriate, licensed hospice inpatient facility employees;

(C) The licensee shall provide and document a volunteer orientation and training program for each volunteer;

(D) Volunteer services involving any direct patient care services shall be provided in accordance with the patient centered plan of care.

(Effective July 31, 2012)

Sec. 19a-495-6g. In-service training and education

(a) In-service educational programs shall be conducted. Such programs shall include but not be limited to:

(1) An orientation program for new personnel, volunteers and contracted staff who provide care to hospice inpatient facility patients. The orientation program shall be provided before the start of employment, volunteering, or provision of contract services at the hospice inpatient facility. The orientation program shall address:

(A) The purpose, goals, mission and philosophy of hospice care; and

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(B) Each individual's specific duties.

(2) Not less than once a year, a training program for employees, volunteers and contracted staff who provide care to hospice inpatient facility patients concerning the development and improvement of hospice-related skills that are identified by the quality assessment and performance improvement program;

(3) Annual training for all employees of the hospice inpatient facility, volunteers and contracted staff in:

(A) Prevention and control of infection;

(B) Patient rights and confidentiality;

(C) Fire prevention and safety; and

(D) Food services and sanitation.

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

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

(Effective July 31, 2012)

Sec. 19a-495-6h. Patient rights and hospice inpatient facility responsibilities

(a) The licensee shall have a written bill of rights and responsibilities governing services, which shall be provided and explained to each patient, family or representative at the time of admission. The medical record of each patient shall contain documentation of compliance with this provision.

(1) The patient's rights and responsibilities shall include, but are not limited to:

(A) Be afforded considerate and respectful care;

(B) Receive effective pain management and symptom control on a twenty-four hour basis for the palliation and management of the terminal illness and related conditions;

(C) Be involved in the development of the patient centered plan of care;

(D) Be fully informed of one's condition;

(E) Refuse care or treatment;

(F) Choose an attending physician;

(G) Have a confidential medical record;

(H) Be free from mistreatment, neglect, or verbal, mental, sexual, and physical abuse, including injuries of unknown source, and misappropriation of patient property;

(I) Receive information about the services covered under the hospice benefits, which shall include but not be limited to a description of available services, unit charges and billing mechanisms;

(J) Receive information about the scope of services that the hospice inpatient facility shall provide and specific limitations on those services including, but not limited to, the hospice inpatient facility's policy on uncompensated care and criteria for admission to and discharge from service;

(K) Receive an explanation of the grievance procedure and the right to file a grievance

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without discrimination or reprisal regarding treatment or care to be provided or regarding the lack of respect for property by anyone providing hospice care;

(L) Receive information concerning the procedure for registering complaints with the commissioner and information regarding the availability of the Medicare toll-free hotline, including telephone number, hours of operation for receiving complaints; and

(M) Be free from unnecessary restraint and seclusion.

(b) The licensee shall ensure compliance with subsection (a) of this section and shall:

(1) Immediately investigate all complaints made by a patient, family, representative, hospice inpatient facility employee, volunteer or contractor regarding the quality or appropriateness of treatment or care provided to a patient;

(2) Ensure that any employee or volunteer of the hospice inpatient facility or any contractor having reasonable cause to suspect or believe that a patient has been abused, neglected or mistreated reports the abuse, neglect or mistreatment to the administrator and Department. An oral report to the administrator shall be made immediately. A written report to the administrator and Department shall be made as soon as practicable but no later than twenty-four hours after said employee, volunteer or contractor has reasonable cause to suspect or believe that a patient has been abused, neglected or mistreated;

(3) Ensure that all allegations of patient abuse, neglect or mistreatment are thoroughly investigated. Such investigation shall be initiated within twenty-four hours of the oral report and concluded within five days of receipt of the written report;

(4) Ensure that any further potential abuse, neglect or mistreatment has been prevented while the investigation is in progress; and

(5) Report the results of all investigations to the Department not more than five days after the investigation has concluded.

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

(Effective July 31, 2012)

Sec. 19a-495-6i. Quality assessment and performance improvement

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

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to demonstrate improvement in hospice inpatient facility performance and promote sustained improvement.

(b) Such plan and program shall be ongoing and shall include:

- (1) Oversight responsibility and program objectives;
- (2) The use of quality indicator data to assess and monitor patient care and services;
- (3) Evidenced based practices and policies for:
 - (A) Pain and symptom management;
 - (B) The prevention and treatment of pressure sores;
 - (C) The prevention of abuse, neglect and mistreatment;
 - (D) The prevention of accidents and injuries; and
 - (E) The prevention, surveillance and control of health care associated infections and communicable diseases.

(4) A method and mechanism for identifying, and as required, reporting:

- (A) Infectious and communicable disease occurrences among patients and personnel;
 - (B) Health care associated infections and a plan for the implementation of actions that are expected to result in improvement and disease prevention;
 - (C) Adverse events; and
 - (D) Potential sources of injuries and medical errors and a plan for the implementation of actions that are expected to result in improvement and prevention of such occurrences.
- (5) Review and investigation of all adverse events;
- (6) Other criteria and data necessary to monitor the quality of patient care; and
- (7) Evidence based practices to identify, evaluate, and correct problems.

(c) The hospice inpatient facility administrator shall designate a licensed employee to coordinate and manage the quality assessment and performance improvement program. The licensed employee shall ensure that:

- (1) Program activities focus on high risk, high volume, or problem-prone areas;
- (2) The program maintains records of appropriate corrective action to address problems identified through the quality assessment and performance improvement program; and
- (3) The outcome of the corrective action is documented and submitted to the governing authority for its review.

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

(e) The functions of the quality assessment and performance improvement committee shall be to:

- (1) Monitor the effectiveness and safety of services and quality of care;
- (2) Identify opportunities for improvement;
- (3) Recommend the frequency and detail of data collection to the governing authority;
- (4) Develop, implement and evaluate performance improvement projects based on the hospice inpatient facility's population and needs that reflect the scope, complexity and past

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performance of the hospice inpatient facility's services and operations;

(5) Ensure there is a rationale as well as a goal and measurable objectives for each project that is implemented;

(6) Ensure progress is documented for each project;

(7) At least annually review and recommend to the governing authority revisions to the hospice inpatient facility's policies relating to:

(A) Quality assessment and improvement activities;

(B) Standards of care;

(C) Professional issues especially as they relate to the delivery of services and findings of the quality assessment and improvement program.

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

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

(Effective July 31, 2012)

Sec. 19a-495-6j. Assessment and patient centered plan of care

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

(b) Not later than five days after a patient's admission to the hospice inpatient facility, the interdisciplinary team shall complete a comprehensive assessment for the patient that shall include but not be limited to the following:

(1) History of pain, symptoms, and treatment;

(2) Characteristics of pain and symptoms;

(3) Physical examination;

(4) Current medical conditions and drugs and biological products;

(5) Patient or family's goal for pain and symptom management;

(6) Condition causing admission;

(7) Relevant history as well as complications and risk factors that affect care planning;

(8) Functional status;

(9) Imminence of death;

(10) Severity of symptoms;

(11) Drug profile;

(12) Bereavement;

(13) The need for referrals or further evaluation by appropriate health professionals; and

(14) Data elements that allow for the measurement of patient outcomes and are related

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to aspects of care.

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

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

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

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

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

(h) The patient centered plan of care shall include, but not be limited to:

(1) Pertinent diagnosis and prognosis;
(2) Interventions to facilitate the management of pain and other symptoms;
(3) Measurable targeted outcomes anticipated from implementing and coordinating the patient centered plan of care;

(4) A detailed statement of the patient and family needs addressing the:

(A) Physical, psychological, social, and spiritual needs;

(B) The scope of services required;

(C) The frequency of services;

(D) The need for respite or general inpatient care;

(E) Nutritional needs;

(F) Drugs and biological products;

(G) Management of pain and control of other symptoms; and

(H) Management of grief.

(5) Drugs and treatments necessary to meet the needs of the patient;

(6) Medical supplies and appliances necessary to meet the needs of the patient;

(7) The interdisciplinary team's documentation of the patient's and family's understanding, involvement, and agreement with the patient centered plan of care; and

(8) Such other relevant modalities of care and services as may be appropriate to meet individual patient and family care needs.

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

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

(Effective July 31, 2012)

Sec. 19a-495-6k. Drugs and biological products

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

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

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

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

(c) The licensee shall ensure that:

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

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

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

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

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

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

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

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

(Effective July 31, 2012)

Sec. 19a-495-6l. Medical supplies and durable equipment

(a) The licensee shall:

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

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

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

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

(Effective July 31, 2012)

Sec. 19a-495-6m. Hospice inpatient facility physical plant

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

(A) Delivering eighty percent of normal power;

(B) Lighting all means of egress;

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

(D) Life support systems; and

(E) Routine patient care.

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

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

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

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

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

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

(i) Patient bathing facilities shall include:

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

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

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

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

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

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

(3) A family and patient common area with not less than two hundred twenty-five square

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feet for every thirty beds;

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

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

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

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

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

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

(B) Food preparation facilities with a lavatory;

(C) Meal service facilities;

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

(E) Pot washing facilities;

(F) Storage areas for supplies and equipment;

(G) Waste storage facilities in a separate room easily accessible to the outside for direct pickup or disposal;

(H) An icemaker-dispenser unit;

(I) A janitor's closet that contains a floor receptacle or service sink; and

(J) Locked storage space for housekeeping equipment and supplies.

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

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

(m) There shall be a laundry service. The licensee may contract for these services. If laundry services are provided on site, they shall comply with the following requirements:

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

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

(3) Storage for laundry supplies;

(4) Deep sink for soaking clothes;

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

(6) Janitor's closet containing a floor receptacle or service sink, and locked storage space for housekeeping equipment and supplies;

(7) Off-site processing requires a soiled linen holding room with hand washing facilities, and a clean linen receiving, holding, inspection and storage room; and

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

(n) Provisions shall be made by the licensee to ensure the following are maintained at all times:

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

(Effective July 31, 2012)

Sec. 19a-495-7—19a-495-499. Reserved

Licensure of private freestanding mental health day treatment facilities, intermediate treatment facilities and psychiatric outpatient clinics for adults

Sec. 19a-495-550. Licensure of private freestanding mental health day treatment facilities, intermediate treatment facilities and psychiatric outpatient clinics for adults

(a) Definitions.

(1) "Aftercare" means the continuing contact of the client with a facility which helps to maintain and increase his or her well-being after the completion or termination of participation in a residential treatment facility;

(2) "Applicant" means any individual, firm, partnership, corporation or association applying for a license or renewal of a license under these regulations;

(3) "Certificate of need" means approval of capital expenditures or functions or services from the Commission on Hospitals and Health Care in accordance with Sections 19a-154 to 19a-155, inclusive, of the Connecticut General Statutes;

(4) "Client" means an individual utilizing the services of and admitted to facility;

(5) "Commissioner" means the Commissioner of Health Services;

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

(7) "Direct care staff" means those persons who are directly involved in the delivery of care or treatment;

(8) "Goals" means attainable ends towards which facility and client activities or services are directed and focused;

(9) "Governing body" means the individual or individuals with the ultimate authority and responsibility for the overall operation of a facility's program;

(10) "Intermediate treatment facility" means a facility which provides evaluative,

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diagnostic, and treatment services in a residential setting for individuals who are experiencing mental, emotional or behavioral problems, disturbances, dysfunctions or disorders as defined in the Diagnostic and Statistical Manual of the American Psychiatric Association, as may be revised from time to time, which do not require a hospital level of treatment;

(11) “License” means the form of permission issued by the department that authorizes the applicant to operate a facility;

(12) “Licensee” means any individual, firm, partnership, corporation or association licensed to conduct a facility;

(13) “Licensed nurse” means registered nurse or practical nurse licensed in Connecticut;

(14) “Day treatment facility” means a facility which provides evaluation, diagnosis, and ambulatory treatment services for individuals who are experiencing mental, emotional or behavioral problems, disturbances, dysfunctions or disorders as defined in the Diagnostic and Statistical Manual of the American Psychiatric Association as it may be revised from time to time and whose unit of service to each client is a minimum of four hours and a maximum of twelve hours;

(15) “Objectives” means specific, measurable and time limited statements designed to achieve overall goals in an incremental process;

(16) “Paraprofessional” means a person trained as a mental health aide to assist a professional;

(17) “Patient rights” means those personal, property, and civil rights to which all clients in any facility defined by these regulations are entitled to under the provisions of Sections 17-206a to 17-206k, inclusive, of the Connecticut General Statutes, as well as all present and revised Federal and State laws, statutes, codes or regulations concerning confidentiality of communication and records;

(18) “Physician” means an individual who has a license to practice medicine in Connecticut;

(19) “Psychiatric outpatient clinic” means a facility which provides evaluation, diagnosis, and ambulatory treatment, to individuals who have mental, emotional or behavioral problems, disturbances, dysfunctions or disorders as defined in the most recent edition of the Diagnostic and Statistical Manual of the American Psychiatric Association, as it may be revised from time to time;

(20) “Psychosocial rehabilitation services” means services which are designed for individuals in need of mental health services which enable individuals to live, learn, work in their own communities with maximum independence;

(21) “Therapeutic recreation” means individual and group activities designed to improve the physical and mental health and condition of each client;

(22) “Treatment services” means those services including, but not limited to, psychosocial rehabilitation and counseling, which are designed to arrest, reverse or ameliorate the client’s mental, emotional or behavioral problems, disturbances, dysfunctions or disorders.

(b) Licensure Procedure

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(1) Commission on Hospitals and Health Care. A facility shall not be constructed, expended or licensed to operate except upon application for, receipt of approval, and compliance with any limitations and conditions required by the Commission on Hospitals and Health Care pursuant to Connecticut General Statutes, Sections 19a-154 through 19a-155, when applicable.

(2) No person shall operate a facility without a license issued by the Department in accordance with Connecticut General Statutes, Section 19a-491.

(3) Application for Licensure.

(A) Application for the grant or renewal of a license to operate a facility shall be made in writing on forms provided by the Department; shall be signed by the person seeking the authority to operate the facility; shall be notarized, and shall include the following information:

- (i) Type of facility proposed to be licensed;
- (ii) Evidence of compliance with local zoning ordinances and local building codes upon initial application;
- (iii) Local fire marshal's annual certificate of compliance;
- (iv) Statement of ownership and operation;
- (v) Certificate of public liability insurance;
- (vi) Current organizational chart;
- (vii) Description of services provided;
- (viii) Names and titles of professional staff;
- (ix) Evidence of financial capacity, upon initial application.

(B) Application for license renewal shall be made in accordance with subdivision A above and not less than 30 days preceding the date of expiration of the facility's current license.

(4) Issuance and Renewal of Licensure.

(A) Upon determination by the Department that a facility is in compliance with the statutes and regulations pertaining to its licensure, the Department shall issue a license or renewal of license to operate a facility for a period not to exceed one year.

(B) The license shall not be transferable to any other person, or facility or location.

(C) Each license shall list on its face, the location and licensed capacity of the facility, the name of the licensee, the doing business as name, the name of the executive director, the name of the director of the facility and the date of issuance and expiration.

(D) The license shall be posted in a conspicuous place in a room accessible to the public.

(E) The licensee shall immediately notify the Department of any change in executive director or director.

(F) The licensee shall notify the Department in writing of any proposed change of ownership, location or services at least ninety days prior to the effective date of such proposed changes.

(5) Suspension, Revocation, Denial or Non-Renewal of License.

(A) A license may be suspended, revoked, denied or its renewal refused whenever in the judgment of the Department the facility:

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- (i) Fails to comply with applicable regulations prescribed by the Commissioner;
- (ii) Fails to comply with applicable federal, state and local laws, ordinances, rules and regulations relating to building, health, fire protection, safety, sanitation and zoning;
- (iii) Furnishes or makes any false or misleading statements to the Department in order to obtain or retain the license.

(B) Refusal to grant the Department access to the facility or to the facility's records shall be grounds for suspension, revocation, denial or non-renewal of the facility's license.

(C) Surrender of license. The facility shall notify in writing each client concerned, the next of kin or legal representative, and any third party payors concerned at least 30 days prior to the voluntary surrender of a facility's license or surrender of license upon the Department's order of revocation, refusal to renew, or suspension of license. In such cases, the current license shall be surrendered, to the Department, within seven days of the termination of operation.

(c) **Multi-Services Facilities.** Each program of a multi-service facility shall conform to those requirements set forth in the Regulations of Connecticut State Agencies governing the applicable program services provided.

(d) **Governing Body and Management.**

(1) A governing body shall be responsible for a facility.

(2) The governing body shall provide written documentation of its source of authority through by-laws or charter.

(3) The governing body shall exercise general direction over the establishment of policies of the organization and may delegate formulation and enactment of procedures in compliance with all local, state, and federal laws. The responsibilities of the governing body shall include:

(A) Adoption and implementation of policies governing all administrative, record management, program evaluation, personnel, fiscal, rehabilitative, clinical, dietary and maintenance aspects of facility operations.

(B) Appointment of a qualified executive director, whose qualifications, authority, and duties are defined in writing.

(C) Provide a safe, equipped physical plant and maintain the facility and services in accordance with any applicable local, state, and federal laws and regulations.

(D) Establishment of an organizational chart which clearly defines lines of responsibility and authority relating to management and maintenance of the facility.

(E) Establishment of mechanisms and documentation of annual review of all facility policies and procedures.

(F) Meet as required but not less than semi-annually.

(G) Documentation of all current agreements with consultants, practitioners, agencies and providers required by the facility in the delivery of services.

(H) Adoption and review of an emergency preparedness plan.

(e) **Director and Executive Director**

(1) Each facility shall have an Executive Director who is accountable to the governing

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body.

(2) Each facility shall employ a director responsible for the day-to-day management of the facility. From and after July 1, 1986 no person shall be employed as a director in a facility unless such person has a minimum of a master's degree in a related human service discipline and five years experience in the field of human service, except that any person employed as a director on June 30, 1986 shall be eligible to continue in the facility of employment without restriction.

(f) Fiscal

(1) Each facility shall have an individual with the designated responsibility for fiscal affairs.

(2) Each facility shall develop and implement written policies and procedures which govern the fiscal operation. Such policies shall include at least the following:

(A) An annual written budget which shall have documentation of review and approval by the governing body. Revisions in the budget during the fiscal year shall be reviewed and approved by the governing body.

(B) Identification of revenues by source and expenditures for component or services.

(C) Identification of the fiscal year.

(D) Documentation of an annual audit by an independent certified public accountant.

(E) Clients' Funds, Monies and Valuable. Intermediate Treatment Facilities:

(i) Whenever a facility receives or disburses client funds or valuables, the facility shall have a written policy and procedure governing this activity and shall document these transactions. Such documentation shall include:

(aa) Source, date and amount of funds or itemized valuables received by the facility for or from each client.

(bb) Receipts, signed and dated by the facility, given to the client verifying receipt of these monies or valuables.

(cc) Amount of the above funds applied toward the services provided to the client by the facility and the amount made available to the client for his or her personal use.

(dd) Receipts, signed and dated by the client verifying monies received for personal use or the identifying of valuables returned to the client.

(ee) For purchases made by the facility on behalf of clients, the client shall sign a receipt which identifies the item, the date of receipt of such item, the amount of such purchase and an acknowledgement of having received the sales slip.

(ff) The facility shall document quarterly in writing to the client by date and amount, monies being held for the client by the facility.

(g) Personnel Practices

(1) Each facility shall have written policies and procedures governing the recruitment, selection, promotion and termination of program staff as well as policies and procedure relating to:

(A) Wage and salary administration;

(B) Employee benefits;

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- (C) Organization chart;
- (D) Employee work rules;
- (E) Disciplinary action including suspension or dismissal of staff;
- (F) Annual job performance evaluation;
- (G) Physician documentation of periodic physical examinations which are performed for the purpose of preventing infection or contagion from communicable disease.

(2) Personnel policies shall ensure a provision that the facility shall not discriminate because of race, color, religious creed, age, sex, marital status, national origin, ancestry, present or past history of mental disorder, mental retardation or physical disability, including, but not limited to, blindness in its hiring, termination, or promotion practices.

(3) Personnel files shall be maintained identifying all personnel, including consultants, and shall be stored in a manner to protect the confidentiality of the employee in accordance with all state or federal laws governing the same. Each file shall contain:

- (A) An application as completed by employee;
- (B) A resume, if applicable;
- (C) Licensed staff credential verification;
- (D) Past employment reference checks;
- (E) Physician documentation of periodic physical examinations which are performed for the purpose of preventing infection or contagion from communicable disease;
- (F) Job performance evaluations;
- (G) Documentation of orientation.

(4) There shall be a written job description for each staff position within the facility which includes:

- (A) Definition of duties to be performed;
- (B) Supervision received;
- (C) Minimum qualifications;
- (D) Effective revision date.

(5) The facility shall have written policies and procedures governing the utilization of volunteers and which shall include:

- (A) Screening of applicants;
- (B) Training;
- (C) Supervision exercised;
- (D) Responsibilities;
- (E) Limitations as to duties;
- (F) Termination of services;
- (G) A provision that volunteers shall not be utilized in lieu of required staff.

(6) Staff Development and Orientation.

(A) Employees shall have made available to them all policies and procedures necessary for them to perform the duties specified in their job descriptions and provide for the safety of the clients. Changes in these policies and procedures shall be communicated in a manner prescribed by the Executive Director.

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(B) Each facility shall establish a plan to provide initial orientation and ongoing training for staff which clearly describes the type of training necessary to maintain current skills and provide for growth in skill and which relates to the objectives of the services offered.

(C) Each facility shall document staff attendance at inservice or workshops, seminars, etc., with the date, topic discussed, and the person conducting the session.

(h) Environment.

(1) Physical Plant.

(A) The standards established by the following sources for the construction, renovation, alteration, maintenance and licensure of all facilities, as they are amended from time to time, are hereby incorporated and made a part hereof by reference:

(i) State of Connecticut Basic Building Code.

(ii) State of Connecticut Fire Safety Code.

(iii) State of Connecticut Public Health Code.

(iv) Local Codes and Ordinances.

(B) Waiver.

(i) The Commissioner or his or her designee, in accordance with the general purposes and intent of these regulations, may waive provisions of subparagraphs (D), (F), (G) and (H) of subdivision (1) of subsection (h) if the Commissioner determines that such waiver would not endanger the life, safety or health of any client. The Commissioner shall have the power to impose conditions which assure the health, safety and welfare of clients upon the grant of such waiver, or to revoke such waiver upon a finding that the health, safety or welfare of any client has been jeopardized.

(ii) Any facility requesting a waiver shall apply in writing to the Department. Such application shall include:

(aa) The specific regulations for which the waiver is requested;

(bb) Reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the facility upon enforcement of the regulations;

(cc) The specific relief requested; and,

(dd) Any documentation which supports the application for waiver.

(iii) In consideration of any application for waiver, the Commissioner or his or her designee may consider the following:

(aa) The level of care provided;

(bb) The maximum client capacity;

(cc) The impact of a waiver on care provided;

(dd) Alternative policies and procedures proposed.

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

(v) Any hearing which may be held in conjunction with an application for waiver shall be held in conformance with Chapter 54 of the Connecticut General Statutes and Department regulations.

(C) Any facility initially licensed after the effective date of these regulations shall conform

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to the construction requirements described herein. Any facility licensed prior to the effective date of these regulations shall comply with construction requirements in effect at the time of licensure, provided, however, that if the Department shall determine that a pre-existing non-conformity creates serious risk of harm to the clients in the facility, the Department may order such facility to comply with the pertinent portion of subdivision (1) of subsection (h) of these regulations. Failure of the facility to comply with a Department order under this subparagraph shall be grounds for action against the license.

(D) General

(i) The facility shall be structurally sound and equipped in a safe and sanitary manner to prevent or minimize all health and fire hazards.

(ii) The building equipment and services shall be maintained in a good state of repair. A maintenance program shall be established to insure that the interior, exterior and grounds of the building are maintained, clean, and free from accumulations of refuse, dilapidated structures, or other health hazards.

(iii) Residential facilities shall provide for an individualized social and physical environment, including opportunities for privacy, in clearly defined living, sleeping and personal care spaces, and shall be sufficient in size to accommodate comfortably the approved number of clients and staff.

(E) New Facilities, Expansions and Conversions. Notification of new construction, expansions and conversions indicating the proposed use shall be submitted to the Department sixty days prior to the initiation of construction.

(F) Basic Requirements.

(i) Site locations shall be accessible to the community, to emergency service vehicles, and where possible to public transportation.

(ii) Established walkways shall be provided for each exit from the building leading to a driveway or street.

(iii) Administration and Public Areas. The following shall be provided based on program needs:

(aa) A lobby with a reception counter or desk, or a waiting area.

(bb) Access to public toilet facilities and telephones.

(cc) Storage space for office equipment, supplies and records.

(G) Special Requirements. Psychiatric Outpatient Clinics and Day Treatment Facilities. Each facility shall have private office space to conduct direct client services.

(H) Special Requirements. Intermediate Treatment Facilities.

(i) Each facility shall have a private office in which to conduct client interviews.

(ii) Client bedrooms shall meet the following requirements:

(aa) There shall be no more than 3 beds per bedroom;

(bb) Net minimum room floor area shall not be less than 80 square feet in single bedrooms and 70 square feet per bed in multi-bed rooms. A variance of this requirement up to 10% of the total square footage will be permitted if it can be demonstrated that the room configuration results in comfortable accommodation;

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- (cc) Provide a minimum of three (3) feet space between beds in multi-bed rooms;
- (dd) Bunk beds shall not be used;
- (ee) All client bedrooms shall open to a common corridor or common room which leads to an exit;
- (ff) No client bedroom shall be located in an attic or basement;
- (gg) Each client bedroom shall be an outside room with not less than 10% of its total area, devoted to windows;
- (hh) Windows shall be equipped with insect screening;
- (ii) No room, which opens into the kitchen or necessitates passing through the kitchen to reach any other part of the facility, shall be used as a bedroom; except when occupancy is 15 or less beds;
- (jj) Separate rooms shall be provided for men and women;
- (kk) The room furnishings for each client shall include: a single bed with a clean, unstained and washable mattress with a mattress pad, an available reading light, one dresser with three drawers, one closet or wardrobe to hang clothing, one chair and one mirror per room.
- (iii) Toilet and Bathing Facilities.
 - (aa) One toilet room shall be directly accessible for each six persons without going through another bedroom; in addition to a toilet, each room shall be equipped with a sink, mirror, toilet tissue, soap, single use disposable paper towels and receptacle.
 - (bb) A minimum of one toilet, one handwashing sink and one bathtub or shower shall be provided on each residential floor.
 - (cc) One shower or bathtub shall be provided for each eight clients or fraction thereof in an individual room or enclosure which provides space for the private use of the bathing fixture and for drying and dressing.
 - (dd) All toilet and bathing facilities shall be well lighted, and ventilated to the outside atmosphere, either by means of a window that can be opened, or by exhaust fans.
- (iv) Service Areas. Each facility shall provide adequate areas for living, dining and individual or general program functions.
 - (aa) A space for group therapy activities shall be provided.
 - (bb) Multi-purpose rooms shall be provided for general meetings, educational and other social purposes. The total area set aside for these purposes shall not be less than 25 square feet times total licensed capacity.
 - (cc) Dining area sufficient to accommodate all clients in one sitting shall be provided.
- (v) Laundry Service.
 - (aa) If clients are responsible for their own laundry, residential type laundry facilities shall be provided or made accessible in the community.
 - (bb) Linen and towels sufficient for two times the capacity of the facilities are to be provided.
 - (cc) Each facility shall supply bedding for each client which consists of at least one blanket, one bedspread, one pillow, one pillow cover, one pillow case, one bottom sheet,

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one top sheet and one mattress pad. Bedding shall be appropriate to weather and climate.

(dd) If linen is to be processed on the site, space for soiled linen sorting, adequate laundry equipment including washer and dryer, and clean linen storage space shall be provided.

(ee) If linen is processed outside of the facility, a soiled linen holding room and a clean linen storage room or area shall be provided.

(vi) Environmental Details.

(aa) All areas used by clients shall have temperatures of not less than 68° F.

(bb) The hot water heating equipment shall have sufficient capacity to supply hot water at the temperature of 110–120° F and at amounts required at all times.

(cc) Only central or permanently installed heating systems shall be used.

(dd) All doors to client bathrooms, toilet rooms, and bedrooms shall be equipped with hardware which will permit access in an emergency.

(ee) Walls, ceilings and floors shall be maintained in a good state of repair and be washable or easily cleanable.

(ff) Hot water or steam pipes located in areas accessible to clients shall have adequate protective insulation.

(gg) Each building shall be provided with a telephone that is accessible for emergency purposes. The facility shall have a public telephone for client use.

(hh) Provisions shall be made to assure an individual's privacy in the bathroom areas.

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

(jj) All rooms shall have general lighting and all bedrooms, toilet rooms and offices shall have at least one light fixture switch at the entrance to each room.

(kk) Items such as drinking fountains, telephone booths, vending machines, and portable equipment shall not reduce the corridor width below the width of three feet.

(ll) All doors to client bedrooms and means of egress shall be of a swing type.

(mm) The minimum width of all doors to rooms accessible to clients shall be 2' 4"; except that bathroom doors shall be not less than 2'.

(nn) Effective measures shall be taken to protect against the entrance into the facility or breeding on the premises of vermin. During the season when flies are prevalent, all openings into outer air shall be effectively screened and doors shall be provided to prevent the entrance of flies.

(2) Emergency and Disaster Procedures.

(A) Each facility shall establish written policies and procedures governing appropriate intervention in the event of an emergency or disaster. Such procedures shall require:

(i) Orientation of all staff, and volunteers, in the use of fire extinguishers. Such orientation shall be documented.

(ii) Orientation of all staff, including volunteers, and clients to the written evacuation plan and the diagram of the facility exit routes.

(iii) There shall be documentation of staff orientation to emergency and disaster procedures.

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(iv) Fire plans and procedures shall be posted in conspicuous areas throughout the facility.

(v) Emergency and disaster drills shall be conducted on a monthly basis for all residential facilities and on a quarterly basis for all non-residential treatment facilities. Resident facilities shall conduct such drills at various times to provide for three drills per shift in a year.

(vi) Each facility shall have a plan for assigning staff specific duties in the event of disaster or emergency.

(vii) Each facility shall develop and implement a written plan for the checking of first aid supplies on a monthly basis. The plan shall specify the supplies to be stocked, the required amounts of each supply and position title of any staff person responsible for the audit. The facility shall document when first aid supplies are checked.

(B) Special Requirements. Intermediate Treatment Facilities.

(i) Each facility shall have written plans for a provision of temporary physical facilities, to include shelter and food services for their clients, in the event the facility becomes uninhabitable due to disaster or emergency.

(ii) Special Requirements. Psychiatric Outpatient Clinics or Day Treatment Facilities. Each non-residential facility shall have written plan to provide appropriate services for their clients in the event the facility becomes unusable due to disaster or emergency.

(3) Dietary Facilities.

(A) Each intermediate treatment facility shall provide an organized dietary service. It shall include space and equipment for storage, preparation, assembling and serving food, cleaning dishes and disposal of garbage. The following shall apply:

(i) Kitchens shall be separate from other areas and large enough to allow for adequate equipment to prepare and keep food properly.

(ii) All equipment and appliances shall be installed to permit thorough cleaning of the equipment, the floor and the walls around them. The floor surface shall be of non-absorbent material.

(iii) A dishwashing machine shall be provided in any facility with ten or more beds. Commercial dishwashing machines shall be provided in any facility with twenty-five or more beds and shall be separated from the food preparation areas.

(iv) A handwashing sink with a soap dispenser shall be provided. Single service towels and a covered waste receptacle shall be provided in the kitchen area for the exclusive use of the kitchen personnel.

(v) Dry storage space, for at least a three-day supply of food.

(vi) Functional refrigerators and freezers shall be provided for the storage of food to meet the needs of the clients.

(vii) Trash shall be kept in covered receptacles outside the facility.

(viii) A ventilation system shall be provided in the kitchen area.

(4) Pharmaceutical Facilities. Each facility which dispenses medications shall provide: locked storage space; handwashing sink, a non-portable steel narcotics locker; soap and paper towel dispenser; and equipment for preparing and dispensing of medications.

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(i) Food Services. Intermediate Treatment Facility.

(1) Each facility that provides residential services, shall have a written plan for the provision of food services.

(2) Each facility shall have a dietitian who shall provide consultation on a semiannual basis. Records of such consultation shall be maintained by the facility.

(3) Each facility shall have written menus for the minimum of a one week period in advance which includes breakfast, lunch and dinner. Substitutions in planned menus shall be recorded on the menu in advance whenever possible. Menus and substitutions shall be kept on file for at least a thirty day period.

(4) Menu selection and food preparation shall take into consideration the clients' cultural background, personal preferences, food habits and dietary needs.

(5) A minimum of three days supply of staple foods shall be maintained at all times.

(j) Accident or Incident Reports.

(1) Classification. All accident or incident reports to the department shall employ the following classifications of such events:

Class A: One which has resulted or had the potential to result in serious injury to death.

Class B: One which has interrupted or has the potential to interrupt the services provided by the facility.

Class C: One which results in legal action against the facility.

(2) Report. The Executive Director shall report any accident or incident to the Department as follows:

Class A & B: Immediately by telephone to the department, to be confirmed by written report as provided herein within seventy-two hours of said events.

Class C: Written report to the department as provided herein within seventy-two hours of the initiation of legal action.

(3) Each written report shall contain the following information:

(A) Date of report and date of event.

(B) Facility classification.

(C) Identification of the individuals affected by the event, including, where available: client identification and age, name of employee, visitor, or other, nature of incident, action taken by the facility and disposition.

(D) If an affected individual is or was at the time of the reported event a client of the facility:

(i) Date of admission;

(ii) Current diagnosis;

(iii) Physical and mental status prior to the event; and

(iv) Physical and mental status after the event.

(E) The location, nature and brief description of the event.

(F) The name of the physician consulted, if any, and time of notification of the physician and a report summarizing any subsequent physical examination, including findings and orders.

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(G) The name of any witnesses to the event.

(H) Any other information deemed relevant by the reporting authority.

(I) The signature of the person who prepared the report and the Executive Director.

(4) Numbering. Each report shall be identified on each page with a number as follows: the number appearing on the facility license; the last two digits of the calendar year; the sequential number of the report during the calendar year.

(5) The Executive Director shall submit subsequent reports relevant to any accident or incident.

(k) Service Operations

(1) Program Evaluation.

(A) Each facility shall have established goals and objectives appropriate to the population served and program model.

(B) Each facility shall establish a program evaluation process, which will determine the degree to which these goals and objectives are being met. Documentation of corrective action shall be based on this evaluative process.

(2) Client Records.

(A) An organized written record for each client shall be maintained which contains current information sufficient for identification and assessment for the provision of appropriate care, treatment and other applicable services.

(B) Each client record shall contain the following:

(i) Documentation of advisement of client rights;

(ii) Social or family background;

(iii) Next of kin or other designated individual to be notified in the event of an emergency;

(iv) Physical examination inclusive of medical history when indicated;

(v) Substance abuse history, if applicable;

(vi) Educational background;

(vii) Employment history;

(viii) Referral source summary to include reason for referral and medications at time of referral;

(ix) Legal history;

(x) Releases and notations of release of information.

(C) Each client record shall contain an individualized care plan which must include:

(i) Specific objectives which are related to stated goals;

(ii) Name of assigned staff person to develop and monitor the individualized care plan;

(iii) Description of the type and frequency of services to be provided;

(iv) Provision for periodic review by designated staff member;

(v) Description of supportive services determined to be needed;

(vi) Signatures of the counselor or other staff person formulating the individualized care plan.

(D) Each individual client record shall contain progress notes which document services provided to the client and progress made towards goals and objectives in accordance with

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the individualized care plan. Each note shall be entered in ink by a direct care staff member or consultant and shall be dated, legible, signed by the person making the entry and his or her position title.

(E) Each individual client record shall contain a current list of all medications and instructions for administration.

(F) Each client record shall contain documentation of the periodic individualized care plan review. Such documentation shall include the date of the review, person conducting the review and any changes in the individualized care plan as the result of the review.

(G) Each client records shall contain a discharge summary which has been written within fifteen days of the individual client's discharge date. This summary shall:

- (i) Indicate the client's progress towards the established individualized care plan goals;
- (ii) Address original reason for referral;
- (iii) Describe the type, frequency and duration of treatment or services;
- (iv) Specify reasons for discharge; and
- (v) Identify expectations for future functioning.

(H) Client records shall be stored in a secure manner and shall be accessible only to authorized persons. Originals or copies of these records shall be retained for at least seven years following discharge. The method of destruction of any such records shall be either incineration or shredding.

(I) Each client record shall have documentation, at the time of admission, or an initial assessment which identifies the client's appropriateness for participation in the facility.

(J) Each client record shall contain a comprehensive written assessment which shall be written within 15 days of admission and include identification of individual needs of the client as well as the approaches to meet each identified need, i.e., psychiatric, psychological, recreational, creative arts, dietary, nursing and social work as applicable.

(K) A comprehensive individualized care plan based on the above assessment shall be developed and reviewed as follows:

- (i) Day and Intermediate Treatment Facilities.
 - (aa) Developed no later than thirty calendar days after admission.
 - (bb) Reviewed at least every sixty calendar days.
- (ii) Psychiatric Outpatient Clinics.
 - (aa) Developed no later than thirty calendar days after admission.
 - (bb) Reviewed at least every ninety calendar days.
- (3) Admissions, Discharge, or Referrals.

Each facility shall have written policies and procedures governing admissions, discharges, and referrals. Such policies shall include:

- (A) Identification of the target population and the length of stay;
- (B) Criteria for assessing the clients for appropriateness for the facility;
- (C) Criteria for admission and readmission;
- (D) The admission process;
- (E) Criteria for voluntary and involuntary discharge;

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(F) Discharge summaries;

(G) Referrals.

(4) Other Agency Agreements. Each facility shall maintain a written agreement with a hospital for emergency and inpatient treatment.

(5) Staffing.

(A) Each facility shall have a sufficient number of staff qualified by virtue of education and training to meet the needs of the clients and the programs or services the facility proposes to deliver.

(B) The services of a consultant may be utilized, in the area of treatment, to meet the needs of the facility or client.

(i) Each consultant to a facility shall have a minimum of a masters degree or license or registration in the field, or in a related area, to which he or she is providing consultation.

(ii) Each consultant's hours and duties shall be documented.

(C) Each facility shall designate a psychiatrist to be responsible for diagnostic and treatment services, whose hours and duties shall be documented. Such psychiatrist shall be a currently licensed physician in the State of Connecticut who is certified or is eligible for certification by the American Board of Psychiatry.

(D) Each psychiatric outpatient clinic and day treatment facility which administers medication shall have a licensed nurse on duty to administer such medications.

(E) Intermediate treatment facilities during sleeping hours shall have at least one direct care staff person on duty and awake for each thirty clients or fraction thereof.

(F) Intermediate treatment facilities during non-sleeping hours shall at no time have less than one direct care staff person on duty for each ten clients or fraction thereof.

(G) At no time shall there be less than two direct care staff on duty in any intermediate treatment facility.

(H) Each intermediate treatment facility shall have a qualified person designated responsible for a program of recreation or creative arts activities.

(I) Each intermediate treatment facility shall have a licensed nurse on duty and awake at all times.

(6) Medication Control.

(A) Each facility shall have policies and procedures governing medications as they relate to the services provided. Such policies and procedures shall include:

(i) Identification of the system to be utilized;

(ii) Method of obtaining prescription medications;

(iii) Storage of medications;

(iv) Establishment of reasonable controls and monitoring methods necessary to assure the safety of all clients;

(v) Method of destruction and documentation of controlled and uncontrolled substances;

(vi) Disposal of unused medication; and

(vii) A provision for staff education related to medication. This shall be conducted on a semi-annual basis.

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(B) Facilities which administer drugs obtained pursuant to the prescriptions of physicians in a therapeutic program shall provide medical, pharmaceutical and nursing services which are consistent with the needs of the clients, the stated purposes of the facility, and State, Federal laws.

(Effective June 25, 1990)

Licensure of Private Freestanding Mental Health Residential Living Centers

Sec. 19a-495-551. Licensure of private freestanding mental health residential living centers

(a) Definitions

(1) “Applicant” means any individual, firm, partnership, corporation or association applying for a license or renewal of a license under these regulations;

(2) “Commissioner” means the Commissioner of Health Services;

(3) “Department” means the Connecticut Department of Health Services;

(4) “Director” means the individual designated by the executive director as directly responsible for the management of the residence;

(5) “Executive director” means the Chief Executive Officer of an agency or facility;

(6) “Goals” means attainable ends towards which residence or resident activities or services are directed and focused;

(7) “Governing body” means the individual or individuals with the ultimate authority and responsibility for the overall operation of a residence’s program;

(8) “License” means the form of permission issued by the department that authorizes the applicant to operate a residence;

(9) “Licensee” means any individual, firm, partnership, corporation or association licensed to conduct a residence;

(10) “Objectives” means statements designed to achieve measurable and time limited statements of overall goals in an incremental process;

(11) “Physician” means an individual who has a license to practice medicine in Connecticut;

(12) “Psychosocial rehabilitation services” means services which are designed for individuals in need of mental health services which enable individuals to live, learn, and/or work in their own communities with maximum independence;

(13) “Resident” means an individual requiring the services of and admitted to a residential living center.

(14) “Residential Living Center” or “residence” means a facility which provides a supervised, structured and supportive group living arrangement which includes psychosocial rehabilitation services and may also provide assistance in obtaining necessary community services to persons in need of mental health service;

(b) Licensure Procedure

(1) No person shall operate a residence without a license issued by the Department in

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accordance with Connecticut General Statutes, Section 19a-491.

(2) Application for Licensure

(A) Application for the grant or renewal of a license to operate a residence shall be made in writing on forms provided by the Department; shall be signed by the person seeking the authority to operate the residence; shall be notarized, and shall include the following information:

(i) Evidence of compliance with local zoning ordinances and local building codes upon initial application and when applicable;

(ii) Local fire marshal's annual certificate of compliance;

(iii) Statement of ownership and operation;

(iv) Certificate of public liability insurance;

(v) Current organizational chart;

(vi) Description of services provided;

(vii) Names and titles of professional staff;

(viii) Evidence of financial capacity upon initial application.

(B) Application for license renewal shall be made in accordance with subdivision (A) above not less than 30 days preceding the date of expiration of the residence's current license.

(3) Issuance and Renewal of Licensure

(A) Upon determination by the Department that a residence is in compliance with the statutes and regulations pertaining to its licensure, the Department shall issue a license or renewal of license to operate a residence for a period not to exceed one year.

(B) The license shall not be transferable to any other person, residence or location.

(C) Each license shall list on its face, the location and licensed capacity of the residence, the name of the licensee, the doing business as name, the name of the executive director, the name of the director of the residence and the date of issuance and expiration.

(D) The license shall be posted in a conspicuous place in a room accessible to the public.

(E) The licensure shall immediately notify the Department of any change in executive director or director.

(F) The licensee shall notify the Department in writing of any proposed change of ownership, location or services at least ninety days prior to the effective date of such proposed change.

(4) Suspension, Revocation, Denial or Non-Renewal of License

(A) A license may be suspended, revoked, denied or its renewal refused whenever in the judgment of the Department the residence:

(i) Fails to comply with applicable regulations prescribed by the Commissioner;

(ii) Fails to comply with applicable federal, state and local laws, ordinances, rules and regulations relating to building, health, fire protection, safety, sanitation and zoning;

(iii) Furnishes or makes any false or misleading statements to the Department in order to obtain or retain the license.

(B) Refusal to grant the Department access to the residence or to the residence's records

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shall be grounds for suspension, revocation, denial or non-renewal of the residence's license.

(C) Surrender of license. The residence shall in writing notify each resident concerned, the next of kin or legal representative, and any third party payors concerned at least 30 days prior to the voluntary surrender of a residence's license or surrender of license upon the Department's order or revocation, refusal to renew or suspension of license. In such cases, the license shall be surrendered to the Department within the seven days of the termination of operation.

(c) **Multi-Services Residences.** Each program of a multi-service residence shall conform to those requirements set forth in the Regulations of Connecticut State Agencies governing the applicable program services provided.

(d) **Governing Body and Management**

(1) Every residence shall be responsible to a governing body.

(2) The governing body shall provide written documentation of its source of authority through by-laws or charter.

(3) The governing body shall exercise general direction over the establishment of policies of the organization and may delegate formulation and enactment of procedures in compliance with all local, state, and federal laws. The responsibility of the governing body shall include:

(A) Adoption and implementation of policies governing all administrative, record management, program evaluation, personnel, fiscal, rehabilitative, dietary and maintenance aspects of residence operations.

(B) Appointment of a qualified Executive Director whose qualifications, authority, and duties are defined in writing.

(C) Provide a safe, equipped physical plant and maintain the residence and services in accordance with any applicable local, state and federal laws and regulations.

(D) Establishment of an organizational chart which clearly defines lines of responsibility and authority relating to management and maintenance of the residence.

(E) Establishment of mechanisms and documentation of annual review of all residence policies and procedures.

(F) Meet as required but not less than semi-annually.

(G) Documentation of all current agreements with consultants, practitioners, agencies and providers required by the residence in the delivery of services.

(H) Adoption and review of an emergency preparedness plan.

(e) **Director and Executive Director**

(1) Each residence shall have an executive director who is the chief executive officer and shall be accountable to the governing body.

(2) Each residence shall employ a director responsible for the day to day management of the residence. From and after July 1, 1986 no person shall be employed as a director in a residence unless such person has a minimum of a baccalaureate degree in a related human service discipline plus three years experience in the field of mental health or three years experience in an administrative or supervisory capacity in the field of human services,

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except that any person employed as a director on June 30, 1986 shall be eligible to continue in the facility of employment without restriction.

(f) Fiscal

(1) The governing body of each residence shall have or delegate an individual responsibility for fiscal affairs.

(2) Each residence shall develop and implement written policies and procedures which governs the fiscal operation, such policies shall include at least the following:

(A) An annual written budget which shall have documentation of review and approval by the governing body. Revisions in the budget during the fiscal year shall be reviewed and approved by the fiscal officer designated by the governing body.

(B) Identification of revenues by source and expenditures of component/services.

(C) Identification of the fiscal year from the beginning to ending date.

(D) Documentation of an annual audit by an independent certified public accountant.

(E) Resident's Funds, Monies and Valuables.

(i) Whenever a residence receives or disburses resident funds or valuables, the residence shall have and implement a written policy and procedure governing this activity and shall document these transactions. Such documentation shall include:

(aa) Source, date and amount of funds or itemized valuables received by the residence for or from each resident.

(bb) Receipts, signed and dated by the residence, given to the resident verifying receipt of the monies or valuables.

(cc) Amount of the above funds applied toward the services provided to the resident by the residence and the amount made available to the resident for his/her personal use.

(dd) Receipts, signed and dated by the resident verifying monies received for personal use or the identifying of valuables returned to the resident.

(ee) For purchases made by the residence on behalf of residents, the resident shall sign a receipt which identifies the item, the date of receipt of such item, the amount of such purchase and an acknowledgement of having received the sales slip.

(ff) The residence shall document quarterly in writing to the resident by date and amount, monies being held for the resident by the residence.

(g) Personnel Practices

(1) Each residence shall have written policies and procedures governing the recruitment, selection, promotion and termination of program staff as well as policies and procedures relating to:

(A) Wage and salary administration;

(B) Employee benefits;

(C) Table of organization;

(D) Employee work rules;

(E) Disciplinary action including supervision or dismissal of staff;

(F) Annual job performance evaluation;

(G) Physician documentation of periodic physical examinations which are performed for

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the purpose of preventing infection or contagion from communicable disease.

(2) Personnel policies shall ensure a provision that the residence shall not discriminate because of race, color, religious creed, age, sex, marital status, national origin, ancestry, present or past history of mental disorder, mental retardation or physical disability, including, but not limited to, blindness in its hiring, termination, or promotion practices.

(3) Personnel files shall be maintained identifying all personnel, including consultants, and shall be stored in a manner to protect the confidentiality of the employee in accordance with all state and federal laws governing the same. Each file shall contain:

- (A) An application as completed by employee;
- (B) A resume, if applicable;
- (C) Licensed staff credential verification;
- (D) Past employment or experience verification;
- (E) Physician documentation of periodic physical examinations which are performed for the purpose of preventing infection or contagion from communicable disease;
- (F) Job performance evaluations;
- (G) Documentation of orientation.

(4) There shall be a written job description for each staff position within the residence and which includes:

- (A) Definition of duties to be performed;
- (B) Supervision received;
- (C) Minimum qualifications;
- (D) Effective or revision date.

(5) Any residence which utilizes volunteers shall have written policies and procedures governing their utilization and which shall include:

- (A) Screening of applicants;
 - (B) Training;
 - (C) Supervision exercised;
 - (D) Responsibilities;
 - (E) Limitations as to duties;
 - (F) Termination of services;
 - (G) A provision that volunteers shall not be utilized in lieu of required staff.
- (6) Staff Development and Orientation

(A) Employees shall have made available to them all policies and procedures necessary for them to perform the duties specified in their job descriptions and provide for the safety of the residents. Changes in these policies and procedures shall be communicated in a manner prescribed by the Executive Director.

(B) Each residence shall establish a plan providing initial orientation and ongoing training to staff which clearly describes the type and extent of training necessary to maintain current skills, provides for growth in skill and which relate to the objectives of the services offered.

(C) Each residence shall document staff attendance at inservice or workshops, seminars, etc., with the date, topic discussed, and any presenting person.

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(h) Environment

(1) Physical Plant

(A) The standards established by the following sources for the construction, renovation, alteration, maintenance and licensure of all residences, as they are amended from time to time, are hereby incorporated and made a part hereof by reference:

- (i) State of Connecticut Basic Building Code.
- (ii) State of Connecticut Fire Safety Code.
- (iii) State of Connecticut Public Health Code.
- (iv) Local Codes and Ordinances.

(B) Any residence initially licensed after the effective date of these regulations shall conform to the construction requirements described herein. Any residence that was licensed prior to the effective date of these regulations shall comply with the construction requirements in effect at the time of licensure, provided, however, that if the department determines that a pre-existing non-conformity with subdivision (1) of subsection (h) of these regulations creates serious risk or harm to residents in the residence, the commissioner may order such residence to comply with the pertinent portion of subdivision (1) this subsection of (h). Failure to comply with the commissioner's order will be grounds for suspension, revocation or non-renewal of the license.

(C) Waiver.

(i) The Commissioner, in accordance with the general purposes and intent of these regulations, may waive provisions of subparagraphs (D) and (F) of subdivision (1) of subsection (h) if the Commissioner determines that such waiver would not endanger the life, safety or health of any resident. The Commissioner shall have the power to impose conditions which assure the health, safety and welfare of residents upon the grant of such waiver, or to revoke such waiver upon a finding that the health, safety or welfare of any resident has been jeopardized.

(ii) Any residence requesting a waiver shall apply in writing to the Department. Such application shall include:

- (aa) The specific regulations for which the waiver is requested;
 - (bb) Reasons for requesting a waiver, including a statement of the type and degree of hardship that would result to the residence upon enforcement of the regulations;
 - (cc) The specific relief requested; and
 - (dd) Any documentation which supports the application for waiver.
- (iii) In consideration of any application for waiver, the Commissioner or his or her designee may consider the following:
- (aa) The level of care provided;
 - (bb) The maximum resident capacity;
 - (cc) The impact of a waiver on care provided;
 - (dd) Alternative policies or procedures proposed.
- (iv) The Department reserves the right to request additional information before processing an application for waiver.

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(v) Any hearing which may be held in conjunction with an application for waiver shall be held in conformance with Chapter 54 of the Connecticut General Statutes and Department regulations.

(D) General

(i) The residence shall be structurally sound and equipped in a safe and sanitary manner to prevent or minimize all health and fire hazards.

(ii) Any building, equipment and services shall be maintained in a good state of repair. A maintenance program shall be established to insure that the interior, exterior and grounds of the building are maintained, kept clean, and orderly, and free from accumulations of refuse, dilapidated structures, or other health hazards.

(iii) The residence shall provide for an individualized social and physical environment, including opportunities for privacy, in clearly defined living, sleeping and personal care spaces, and shall be sufficient in size to accommodate comfortably the approved number of residents and staff.

(E) New Facilities, Expansions and Conversions. Notification of new construction, or expansions, indicating the proposed use, shall be submitted to the State Department of Health Services, sixty days prior to the initiation of construction.

(F) Basic Requirements

(i) Site locations shall be accessible to the community, to emergency service vehicles, and where possible to public transportation.

(ii) Established walkways shall be provided for each exit from the building leading to a driveway or street.

(iii) Each residence shall have a private office in which to conduct resident interviews.

(iv) Resident bedrooms shall meet the following requirements:

(aa) There shall be no more than 3 beds per bedroom;

(bb) Net minimum room floor area shall be not less than 80 square feet in single bed rooms and 70 square feet per bed in multi-bed rooms. A variance of this requirement up to 10% of the total square footage will be permitted if it can be demonstrated that the room configuration results in comfortable accommodation;

(cc) Provide a minimum of three (3) feet space between beds in multi-bed rooms;

(dd) Bunk beds shall not be used;

(ee) All resident rooms shall open to a common corridor or common room which leads to an exit;

(ff) No resident room shall be located in an attic or basement;

(gg) Each resident bedroom shall be an outside room with not less than 10% of its floor area, excluding closets, devoted to windows;

(hh) Windows shall be equipped with insect screening;

(ii) No room which opens into the kitchen or necessitates passing through the kitchen to reach any other part of the residence shall be used as a bedroom; except when occupancy is 15 or less beds;

(jj) Separate rooms shall be provided for men and women;

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(kk) The room furnishings for each resident shall include: a single bed with a clean unstained mattress, a washable mattress pad or cover, an available reading light, one dresser with three drawers, one closet or wardrobe to hang clothing, and one chair. One mirror per room shall be provided.

(v) Toilet and Bathing Facilities.

(aa) One toilet room shall be directly accessible for each six persons without going through another bedroom; in addition to a toilet, each room shall be equipped with a sink, mirror, toilet tissue, soap, single use disposable towels and receptacle.

(bb) A minimum of one toilet, one handwashing sink and one bathtub or shower shall be provided on each residential floor.

(cc) One shower or bathtub shall be provided for each eight residents or fraction thereof in an individual room or enclosure which provides space for the private use of the bathing fixture and for drying and dressing.

(dd) All toilet and bathing facilities shall be well lighted, and ventilated to the outside atmosphere, either by means of a window that can be opened, or by exhaust fans.

(vi) Service Areas. Each residence shall provide adequate areas for living, dining and individual or general program functions.

(aa) Multi-purpose rooms shall be provided for general meetings, educational and other social purposes. The total area set aside for these purposes shall not be less than 25 square feet times total licensed capacity.

(bb) Dining area sufficient to accommodate all residents in one sitting shall be provided.

(vii) Laundry Service.

(aa) If residents are responsible for their own laundry, laundry facilities shall be provided or accessible in the community.

(bb) Each residence shall supply towels for any resident who does not have them.

(cc) Each residence shall supply bedding for each resident which consists of at least one blanket, one bedspread, one pillow, one pillow case cover, one pillow case, one top sheet, one bottom sheet and one mattress pad. Bedding shall be appropriate to weather and climate.

(viii) Environmental Details.

(aa) All areas used by residents shall have temperatures of not less than 68°F.

(bb) The hot water heating equipment shall have sufficient capacity to supply hot water at the temperature of 110–120° F and at amounts required at all times.

(cc) Only central heating or permanently installed electric heating systems shall be used.

(dd) All doors to resident bedrooms, toilet rooms and bedrooms shall be equipped with hardware which will permit access in an emergency.

(ee) Walls, ceilings and floors shall be maintained in a good state of repair and be washable or easily cleanable.

(ff) Hot water or steam pipes located in areas accessible to residents shall have adequate protective insulation.

(gg) Each building shall be provided with a telephone that is accessible for emergency purposes. Each building shall have a public telephone for resident use.

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- (hh) Provisions shall be made to assure an individual's privacy in the bathroom areas.
- (ii) The interior of the residence shall be furnished in a home-like setting.
- (jj) All spaces occupied by people, equipment within buildings, approaches to buildings, and parking lots shall have lighting.
- (kk) All rooms shall have general lighting and all bedrooms, toilet rooms and offices shall have at least one light fixture at the entrance to each room.
- (ll) Items such as drinking fountains, telephone booths, vending machines, and portable equipment shall not reduce the corridor width below the width of three feet.
- (mm) All doors to residents bedrooms and means of egress shall be of a swing type.
- (nn) The minimum width of all doors to rooms accessible to residents, shall be 2'-4"; except that bathroom doors shall not be less than 2'.
- (oo) Effective measures shall be taken to protect against the entrance into the residence or breeding on the premises of vermin. During the season when flies are prevalent, all openings into outer air shall be effectively screened and doors shall be provided to prevent the entrance of flies.
- (2) Emergency and Disaster Procedures
 - (A) Each residence shall develop and implement written policies and procedures governing appropriate intervention in the event of an emergency or disaster. Such procedures shall require:
 - (i) Orientation of all staff, residents and volunteers, in the use of fire extinguishers. Such orientation shall be documented.
 - (ii) Orientation of all staff, including volunteers, and residents with the written evacuation plan instructions and diagrams for routes of exit.
 - (iii) There shall be documentation of staff and resident orientation to emergency and disaster procedures.
 - (iv) Fire plans and procedures shall be posted in conspicuous areas throughout the residence and in each resident bedroom.
 - (v) Fire drills shall be conducted as often as the local fire marshal recommends, at irregular intervals during the day, evening and night, but not less than monthly.
 - (vi) Each residence shall have documentation of assignment of each staff member to specific duties in the event of disaster or emergency.
 - (vii) Each residence shall develop and implement a written plan for the checking of first aid supplies on a monthly basis. The plan shall specify the supplies to be stocked, the required amounts of each supply and position title of the staff person(s) responsible for the audit. The residence shall document when first aid supplies are checked.
 - (viii) Each residence shall develop and implement written plans for a provision of temporary physical facilities to include shelter and food services for their residents in the event the residence becomes uninhabitable due to disaster or emergency.
- (3) Dietary Facilities
 - (A) Each residence shall have its own kitchen area which shall have the quality and appearance of that in a normal home. It shall include space and equipment for storage,

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preparation, assembling and serving food, cleaning or disposal of dishes and garbage. The following shall apply:

(i) Kitchens shall be separate from other areas and large enough to allow for adequate equipment to prepare and keep food properly.

(ii) All equipment and appliances shall be installed to permit thorough cleaning of the equipment, the floor and the walls around them. The floor surface shall be of non absorbent material.

(iii) A dishwashing machine shall be provided in all residences. Commercial dishwashing machines shall be provided in any residence with twenty-five or more beds and separated from the food preparation areas.

(iv) A sink with a soap dispenser shall be provided. Single service towels and a covered waste receptacle shall be provided in the kitchen area.

(v) Dry storage space, for at least a three day supply of food.

(vi) Functional refrigerators and freezers shall be provided for the storage of food to meet the needs of the residents.

(vii) Trash shall be kept in covered receptacles outside the residence.

(viii) A ventilation system shall be provided in the kitchen area.

(i) Food Services

(1) Each residence shall have a written plan for the provision of food services.

These services shall assure the arrangement for a nourishing and well balanced meals to all residents which includes at least three (3) meals a day provided at normal times.

(2) Each residence shall make available nutritional information such as cookbooks and opportunities for residents to learn cooking techniques as a routine part of the in-house program.

(3) Each residence shall have written menus for the minimum of a one week period in advance which includes available breakfast, foods for lunch and a planned dinner. Substitutions in planned menus shall be recorded on the menu in advance whenever possible. Menus and substitutions shall be kept on file for at least a thirty day period.

(4) Menu selection and food preparation shall take into consideration the residents cultural background, personal preferences, food habits and dietary needs.

(5) A minimum of three days supply of staple foods shall be maintained at all times.

(j) Accident or Incident Reports

(1) Classification. All accident or incident reports to the department shall employ the following classifications of such events:

Class A: One which has resulted in or had the potential to result in serious injury or death.

Class B: One which has interrupted or had the potential to interrupt the services provided by the residence.

Class C: One which results in legal action against the residence.

(2) Report. The Executive Director shall report any accident or incident to the department as follows:

Class A & B: Immediate by telephone to the department, to be confirmed by written

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report as provided herein within seventy-two hours of said events;

Class C: Written report to the department as provided herein within seventy-two hours of the initiation of legal action.

(3) Each written report shall contain the following information:

(A) Date of report and date of event.

(B) Residence classification.

(C) Identification of the individuals affected by the event, including, where available: resident identification, age, and status (or name, of employee, visitor, and other), nature of incident, action taken by the residence and disposition.

(D) If an affected individual is or was at the time of the reported event a resident of the residence:

(i) Date of admission;

(ii) Current diagnosis;

(iii) Physical and mental status prior to the event; and

(iv) Physical and mental status after the event.

(E) The location, nature and brief description of the event.

(F) The name of the physician consulted, if any, and time of notification of the physician and a report summarizing any subsequent physical examination, including findings and orders.

(G) The name of any witnesses to the event.

(H) Any other information deemed relevant by the reporting authority.

(I) The signature of the person who prepared the report and the Executive Director.

(4) Numbering. Each report shall be identified on each page with a number as follows: The number appearing on the residence license; the last two digits of the calendar year; the sequential number of the report during the calendar year.

(5) The Executive Director shall submit subsequent reports relevant to any accident or incident.

(k) **Service Operations**

(1) Program Evaluation

(A) Each residence shall have established goals and objectives appropriate to the population served and program model.

(B) Each residence shall establish a program evaluation process, which will determine the degree to which these goals and objectives are being met. Documentation of corrective action shall be based on this evaluative process.

(2) Resident Rights

(A) Resident Grievance Procedure

(i) A residence shall have a written grievance procedure which shall be available to residents upon admission that identifies areas appropriate for grievance, including, but not limited to dismissal from the residence and a perceived lack of compliance to program rules;

(ii) It shall be the duty of the residence staff to assist the resident in exercising his or her rights under the grievance procedure;

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(iii) It shall be the duty of the governing body or management to adopt a mechanism to review unresolved resident grievances.

(B) Dismissal From the Residence. A resident shall be fully informed of the grounds for his or her dismissal from the residence and in writing when requested by the resident. In the event that a resident is aggrieved by such a dismissal, such resident shall have recourse to the mechanism established by the governing body or management.

(3) Resident Records.

(A) An organized written record for each resident shall be maintained which contains current information sufficient for identification and assessment for the provision of appropriate services.

(B) Each resident record shall contain the following:

- (i) Documentation of advisement of resident rights, program rules and regulations;
- (ii) Psychosocial summary;
- (iii) Next of kin or other designated individual to be notified in the event of an emergency;
- (iv) Physical examination performed by a licensed physician;
- (v) Medical history;
- (vi) Substance abuse history, is applicable;
- (vii) Educational background;
- (viii) Employment history;
- (ix) Referral source summary to include reason for referral and current medications;
- (x) Criminal history, if applicable;
- (xi) Releases and notations of release of information, if any.

(C) Each resident record shall contain an individualized program plan based on individual resident needs, and which shall include:

- (i) Description of the type and frequency of services to be provided by the residence program;
- (ii) Description of the services determined to be needed that are available in the community;
- (iii) Specific objectives which are related to stated goals;
- (iv) Name of assigned staff person to document and monitor the individualized program plan;
- (v) Provision for periodic review by designated staff members(s);
- (vi) Signatures of the resident and counselor or other appropriate staff person to verify participation in the formulation of the individualized program plan.

(D) Each individual resident record shall contain notes which document services provided and progress made towards goals and objectives by the resident in accordance with the individualized program plan. Each note shall be entered in ink by a qualified staff member or consultant and shall be dated, legible, signed by the person making the entry and his or her position title.

(E) Each individual resident record shall contain current list of all medications and instructions for use.

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(F) Each resident record shall contain documentation of the periodic individualized program plan review. Such documentation shall include the date of the review, the name of any person conducting the review and any changes in the individualized program plan as the result of the review.

(G) Each resident record shall contain a departure summary which has been written within fifteen days of the individual resident's leaving the program. This summary shall:

- (i) Indicate the resident's progress towards the objective of independent living.
- (ii) Address original reason for referral, indicating level of functioning upon admission and leaving the residence;
- (iii) Address the services received;
- (iv) Specify reasons for departure and length of stay;
- (v) Describe departure plan.

(H) Current resident records shall be stored in a secure manner on the premises and shall be accessible only to authorized persons. Resident records (originals or copies) shall be preserved in a secure manner for at least five years following departure. The method of destruction of any such records shall be either incineration or shredding.

(I) An individualized program plan shall be written no later than thirty calendar days after entrance into the program and reviewed at least every ninety calendar days thereafter.

(J) Any materials required to be kept confidential under statute shall be maintained separately in the resident's record and apart from program entries.

(4) Admissions, Departure, Referrals. Each residence shall have written policies and procedures governing admissions, departures, and referrals. Such policies shall include:

- (A) Identification of the target population and the length of stay.
- (B) Criteria for assessing the resident for appropriateness for the residence.
- (C) Criteria for admission and readmission.
- (D) The admission process.
- (E) Criteria for dismissal or departure which includes the residents' rights to leave the residence at any time.

(F) Departure summaries.

(G) Referrals.

(5) Each residence shall develop and implement policies and procedures which govern all rehabilitative and support services to be provided on an individual and group basis, which shall include:

(i) Direct training in activities of daily living (i.e., personal hygiene and self care, menu planning and food preparation, household chores, budgeting of money and use of transportation systems and goal setting).

(ii) Assistance in linking residents with those community systems or agencies with which residents may interact (i.e., medical, psychiatric, recreational, social, welfare, educational or vocational).

(iii) Offering assistance to all residents with respect to departure planning.

(6) Each resident in a residence shall have a documented physical examination not more

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than one month prior to or an appointment scheduled not later than five days after admission.

(7) Staffing.

(A) Each residence shall have appropriately qualified individuals, professional or paraprofessionals to meet the needs of the residents and the programs or services the residence proposes to deliver.

(B) When services of a consultant are utilized to meet the needs of the residence or resident, the following shall apply:

(i) Each consultant to a residence shall have a minimum of a masters degree or license or registration in the field, or in a related area, or in lieu thereof, five years demonstrated experience in the field to which he or she is providing consultation.

(ii) Each consultant's hours and duties shall be documented.

(C) There shall be a minimum overall ratio of total number of staff to residents of at least 1:8.

(D) There shall be at least one staff person present when a resident is scheduled to be in the residence, except that such staff person may leave the residence to perform staff duties necessary to meet the needs of the residents, provided that the health and safety of any resident will not be endangered and the activity of the staff person is authorized by the executive director, if possible, or the director is notified of same and the activity is documented in writing.

(E) Provisions shall be made to ensure that sufficient backup personnel are available to respond in emergency situations.

(8) Medication Control

(A) Each residence shall have policies and procedures governing either the self administration or supervised self administration of medication practice of the residence. Such policies and procedures shall include:

(i) Identification of the system to be utilized.

(ii) Storage of medications if a supervised self administration program is utilized.

(iii) Method of destruction and documentation of controlled and uncontrolled substances.

(iv) Disposal of unused medication.

(v) A provision for staff education related to medication. This shall be conducted on a semi-annual basis.

(B) Each residence shall develop and implement a policy and procedure for securing from a referring or attending physician a written assessment of the resident's ability to possess and self-administer medications utilized in the treatment of a psychiatric disorder. This written assessment shall be done upon admission and at least every six months thereafter.

(C) Facilities which utilize a supervised self-administration of medication program shall provide for the following:

(i) Central, non-portable locked storage areas.

(ii) A list of staff members authorized to supervise the self-administration of medications.

(iii) Supervision of self-administration of medication shall be witnessed and documented

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in the resident record after each dose.

(Effective June 25, 1990)

Sec. 19a-495-552—19a-495-559. Reserved

Licensure of Private Freestanding Community Residences

Sec. 19a-495-560. Licensing of private freestanding community residences

(a) **Applicability.** This section applies only to community residences as that term is used in Sections 8-3g, 19a-495 (c), and 19a-507a of the Connecticut General Statutes.

(b) **Definitions.**

(1) “Community residence” means a community residence as defined in the General Statutes of Connecticut, Section 19a-507a (4).

(2) “Mentally ill adult” means a mentally ill adult as defined in the General Statutes of Connecticut, Section 19a-507a (1).

(3) “Regional mental health board” means a regional mental health board, as defined in the General Statutes of Connecticut, Section 17-226j.

(4) “Regional mental health director” means a director appointed by the commissioner of mental health under the General Statutes of Connecticut, Section 17-226g.

(c) **Standards and Requirements.**

(1) Each community residence shall conform to the Regulations of Connecticut State Agencies, Section 19a-495-551 and shall comply with the General Statutes of Connecticut, Sections 19a-507a, 19a-507b, 19a-507c and 19a-507d. In addition, such community residence shall comply with the additional requirements described herein. Where conflicts in the regulations exist, the more stringent shall apply.

(2) Population to be served. Each community residence shall develop and implement a policy and procedure which shall limit admissions in accordance with the General Statutes of Connecticut, Section 19a-507a.

(3) Medication Control. Each community residence shall include a provision in medication control policies and procedures for assuring each residents’ compliance with their individually prescribed medication regimes.

(4) Staffing. Each community residence shall have a minimum overall ratio of total number of staff to residents of at least 1:4.

(5) Program goals and objectives. Each community residence shall conduct a program evaluation on a semi-annual basis. Documentation of the date that the review was conducted, the names of the persons performing the review and content of the review shall be maintained.

(6) Administration. Each community residence shall maintain a copy of the Department of Mental Health evaluation findings and shall document action taken by the residence as a result of these findings.

(7) Human Rights. Each community residence shall post in a conspicuous place the names, addresses and telephone numbers of those federal, state or local agencies for

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residents to refer complaints regarding violations of human rights.

(8) Services to be offered. Each community residence shall provide those services as defined in the General Statutes of Connecticut, Section 19a-507a (4).

(9) Fire Safety.

(A) If the basement area is to be used for client recreation, a second means of exit shall be provided from the basement area exclusive of a hatchway.

(B) A source of continuous illumination not less than five (5) foot candles shall be provided in all exit access corridors.

(C) Emergency lighting shall be provided on each level/floor to illuminate the way to the exitways.

(D) Wall mounted portable extinguishers shall be located on each level of the residence.

(E) If a fireplace is to be used, its opening shall be enclosed with an approved tempered glass screen. The opening shall be permanently sealed if an existing fireplace is not to be used.

(10) Physical Plant. All bathroom electrical receptacles shall be of ground fault interrupter type.

(11) Maintenance. Records of all major maintenance programs undertaken shall be retained for a period of three years.

(Effective December 23, 1987)

Sec. 19a-495-561—19a-495-569. Reserved

Licensure of Private Freestanding Facilities for the Care or the Treatment of Substance Abusive or Dependent Persons

Sec. 19a-495-570. Licensure of private freestanding facilities for the care or the treatment of substance abusive or dependent persons

(a) **Definitions.** For the purposes of these regulations:

(1) “Administering” means an act in which a single dose of a prescribed drug or biological is given to a client by an authorized person in accordance with Federal and State laws and regulations governing such act. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician’s order, giving the individual dose to the proper client, and recording the time and dose given;

(2) “Ambulatory Chemical Detoxification” means a non-residential service to which a person may be admitted for a systematic reduction of physical dependence upon a substance. This service utilizes prescribed chemicals and provides an assessment of needs and motivation of the client toward continuing participation in the treatment process;

(3) “Applicant” means any individual, firm, partnership, corporation, association or other entity applying for a license or renewal of a license under these regulations;

(4) “Auricular Acupuncture” means the insertion of needles at a specified combination of points, on the surface of the outer ear, for the purpose of facilitating the detoxification

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treatment and rehabilitation of substance abusers;

(5) “Biologicals” means products such as antitoxins, antiuvenins, blood, blood derivatives, immune serums, immunologic diagnostic aids, toxoids, vaccines and related articles that are produced under license in accordance with the terms of the Federal Public Health Service Act (58 Stat. 682) approved 7/1/44, as amended;

(6) “Care and Rehabilitation” means a residential service to which a person may be admitted for a structured and supervised group living experience;

(7) “Certificate of Need” means approval of capital expenditures or functions or services from the Commission on Hospitals and Health Care in accordance with the Connecticut General Statutes;

(8) “Chemical Maintenance Treatment” means a service to which a person may be admitted for continued medical supervision of the planned use of a prescribed substance;

(9) “Client” means an individual receiving services from a substance abuse care or treatment facility;

(10) “Community Pharmacy” means a pharmacy licensed pursuant to Section 20-168 of the Connecticut General Statutes;

(11) “Controlled Substance” means a drug, substance, or immediate precursor in Schedule I to V, inclusive, of Section 21a-242 of the Connecticut General Statutes or in regulations promulgated by the Department of Consumer Protection;

(12) “Compounding” means the act of selecting, mixing, combining, measuring, counting or otherwise preparing a drug or medicine;

(13) “Day or Evening Treatment” means a non-residential service to which a person may be admitted for the provision of counseling and other supervised activities, whose daily unit of service to each person is a minimum of four hours, which are designed and developed to arrest, reverse or ameliorate the disorder or problem;

(14) “Department” means the Connecticut Department of Public Health;

(15) “Dispense” means that act of processing a drug for delivery to a client pursuant to the order of a practitioner consisting of: The checking of the directions on the label with the directions on the prescription or order to determine accuracy; the selection of the drug from stock to fill the order; the counting, measuring, compounding or preparing of the drug; the placing of the drug in the proper container; the affixing of the label to the container; and the addition to a written prescription of any required notations;

(16) “Facility” or “Private Freestanding Facility for the Care or Treatment of Substance Abusive or Dependent Persons” means an ambulatory chemical detoxification treatment, care and rehabilitation, chemical maintenance treatment, day or evening treatment, intensive treatment, intermediate and long term treatment, medical triage, outpatient treatment, and residential detoxification and evaluation, center;

(17) “Governing Authority” means the individual or individuals with the ultimate authority and responsibility for the overall operation of a facility’s program;

(18) “Institutional Pharmacy” means that area within a care-giving institution, commonly known as the pharmacy, which is under the direct charge of a full-time pharmacist and

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wherein drugs are stored and regularly compounded or dispensed and the records of such compounding or dispensing maintained, by such pharmacist, including the stock room from which such pharmacist obtains supplies but not including other rooms or areas in such institutions wherein drugs may be stored for the convenience of nursing units, surgical units, laboratories and the like notwithstanding that a pharmacist may control the stocks thereof and may compound or dispense drugs therein. Such full-time pharmacist shall be actively engaged in the practice of pharmacy at such institution no less than thirty-five hours per week;

(19) “Intensive Treatment” means a residential service to which a person may be admitted for twenty-four hour a day supervision and services which are designed to arrest, reverse, or ameliorate the disorder or problem and motivate the person toward recognizing dependence, needs, and to obtain help and make changes;

(20) “Intermediate and Long Term Treatment and Rehabilitation” means a residential service to which a person may be admitted for a structured and supervised group living experience, the aim of which is to arrest, reverse, or ameliorate the problem or disorder and providing ongoing evaluation and activities supportive of integration into educational, vocational, familial or social structures independent of the service;

(21) “Legend Drug” means any article, substance, preparation or device which bears the legend: Caution: Federal Law Prohibits Dispensing Without a Prescription;

(22) “License” means the form of permission issued by the Department that authorizes the applicant to operate a facility;

(23) “Licensee” means the person, firm, corporation, organization or other legal entity licensed to conduct a facility as defined in these regulations;

(24) “Licensed Nurse” means a registered nurse or practical nurse licensed in Connecticut;

(25) “Medical Triage” means a service to which a person may be received for the provision of immediate assessment of symptoms of substance abuse, the immediate care and treatment of these symptoms as necessary, a determination of need for treatment, and assistance in attaining appropriate continued treatment;

(26) “Objectives” means specific statements which are related to the attainment of goals and which shall be quantitative, qualitative and time limited;

(27) “Outpatient Treatment” means a non-residential service to which a person may be admitted for a variety of counseling and other structured activities which are designed to arrest, reverse, ameliorate the disorder or problem;

(28) “Pharmaceutical Services” means the functions and activities encompassing the procurement, dispensing, distribution, storage and control of all pharmaceuticals used within the facility and the monitoring of client drug therapy;

(29) “Pharmacist” means a person duly licensed by the Connecticut Commission of Pharmacy to engage in the practice of pharmacy pursuant to Section 20-170 of the Connecticut General Statutes;

(30) “Pharmacist’s Drug Room” means a room within a care-giving institution or a

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correctional or juvenile training institution, containing drugs in bulk and from which drugs are regularly dispensed for clients of such institution when such institution does not have an institutional pharmacy but employs a pharmacist on a part-time basis;

(31) “Practitioner” means a physician, dentist, or other person authorized to prescribe drugs in the course of professional practice in the State of Connecticut;

(32) “Physician” means an individual licensed pursuant to Section 20-10 of the Connecticut General Statutes;

(33) “Private” means not a unit of or part of a unit of a public or government entity;

(34) “Residential Detoxification and Evaluation” means a residential service to which a person may be admitted for the management of detoxification from a substance or substances of abuse, for an assessment of needs and motivation toward continuing participation in an ongoing treatment process or for a combination of both detoxification and assessment;

(35) “Serious Condition” means an event which significantly jeopardizes or impairs a person’s physical or mental well being.

(36) “Substance Abuse” means the illegal use of a controlled substance; or the compulsive use of alcohol or a drug, apart from or outside of licensed medical care, which usage results in impaired function;

(37) “Substance Dependence” means the physical or psychological reliance upon alcohol or a drug, which reliance results (1) from substance abuse, or (2) from the lawful use of any alcohol or drug for the sole purpose of alleviating such a physical or psychological reliance, or (3) from repeated use of prescribed alcohol or drug within or as part of licensed medical care;

(38) “Substance-Dependent Persons” means individuals who are physically or psychologically reliant upon alcohol or a drug (1) as a result of substance abuse or (2) as a result of the lawful use of alcohol or a drug for the sole purpose of alleviating such a physical or psychological reliance, or (3) as the result of repeated use of prescribed alcohol or drug within or as part of licensed medical care;

(39) “Substance” means any alcohol or drug or controlled substance;

(40) “Treatment” means the engaging of persons in a particular plan of action, the aim of which is to arrest, reverse, ameliorate substance abuse;

(41) “Treatment Services” means those activities which are designed and developed to arrest, reverse or ameliorate the client’s disorder or problem.

(b) Service Classifications Which Are Defined Categories of Care or Treatment Services Contained in These Regulations

(1) Ambulatory Chemical Detoxification Treatment

(2) Care and Rehabilitation

(3) Chemical Maintenance Treatment

(4) Day or Evening Treatment

(5) Intensive Treatment

(6) Intermediate and Long Term Treatment and Rehabilitation

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- (7) Medical Triage
- (8) Outpatient Treatment
- (9) Residential Detoxification and Evaluation
- (c) **Licensure Procedure**

(1) A facility shall not be constructed, expanded or licensed to operate except upon application for, receipt of, and compliance with any limitations and conditions required by the Commission on Hospitals and Health Care per Connecticut General Statutes, Sections 19a-154 through 19a-155, when applicable.

(2) No one shall operate a facility without a license issued by the Department in accordance with Connecticut General Statutes, Section 19a-491.

(3) Application for Licensure.

(A) Application for the grant or renewal of a license to operate a facility shall be made in writing on forms provided by the Department; shall be signed by the applicant seeking the authority to operate the facility; shall be notarized, and shall contain the following information:

(i) Evidence of compliance with local zoning ordinances and local building codes upon initial application;

(ii) Local fire marshal's annual certificate of compliance;

(iii) Statements of ownership and operation;

(iv) Certificate of public liability insurance;

(v) Current organizational chart;

(vi) Licensed classification(s) requested and description of services provided;

(vii) Names and titles of staff;

(B) Application for license renewal shall be made in accordance with Subdivision A above not less than 30 days preceding the date of expiration of the facility's current license.

(4) Issuance and Renewal of Licensure.

(A) Upon determination by the Department that a facility is in compliance with the statutes and regulations pertaining to its licensure, the Department shall issue a license or renewal of license to operate a facility for a period not to exceed one year.

(B) The license shall not be transferable to any other entity, location or facility.

(C) Each license shall list on its face the level of service to be provided, the location and licensed capacity of the facility, where applicable, the name of the licensee, and the name of executive director of the facility, the date of issuance and expiration.

(D) The license shall be posted in a conspicuous place accessible to the public.

(E) The licensee shall notify the Department prior to any change in executive director or change in the facility name.

(F) The licensee shall notify the Department in writing of any proposed change of ownership ninety days prior to the effective date for the purposes of initiating application for a new license.

(G) The licensee shall notify the Department in writing of any proposed change of location or services at least ninety days prior to the effective date of such proposed change.

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(5) Suspension, Revocation, Denial or Non-Renewal of License.

(A) Refusal to grant the Department access to the facility or to the facility's record shall be grounds for denial or revocation of the facility's license.

(B) Surrender of License. The facility shall notify the Department of Health Services, each facility client, and third party payors, as appropriate, in writing, at least 30 days prior to the voluntary surrender of a facility's license. In the event of surrender of license upon the Department's order of revocation, refusal to renew or suspension of license, 30 day written notice to each facility client and third party payors shall be provided by the facility. The license shall be surrendered to the Department within seven days of the termination of operation.

(d) Transfer or Discharge of Clients. Plan Required

Except in an emergency, or when a client leaves of his or her own accord or against program advice, no client shall be transferred or discharged unless a written plan has been developed by the facility staff in conjunction with the client and his or her primary counselor.

(e) Multi-Service Facilities

(1) Each program of a multi-service facility shall conform to those requirements set forth in the Regulations of Connecticut State Agencies governing the applicable program services provided.

(f) Governing Authority and Management

(1) The governing authority shall have overall responsibility for the management and operation of the facility.

(2) The governing authority shall provide written documentation of its source of authority.

(3) The governing authority shall exercise general direction over the establishment of written policies of the organization and may delegate formulation and enactment of same in compliance with all local, state, and federal laws. The responsibilities of the governing authority shall include:

(A) Adoption and implementation of policies governing all administrative, program evaluation, personnel, fiscal, rehabilitative, clinical, dietary and maintenance aspects of facility or operations.

(B) Establishment of the qualifications, authority and duties of the executive director and appointment of a qualified executive director.

(C) Provision of a safe, equipped physical plant and maintenance of the facility and services in accordance with any applicable local, state and federal regulations.

(D) Establishment of an organizational chart which clearly defines lines of responsibility and authority relating to management and maintenance of the facility.

(E) Establishment of procedures for and documentation of, annual review of all facility policies and procedures.

(F) Meet not less than semi-annually.

(G) Documentation of all current agreements with consultants or practitioners required by the facility in the delivery services.

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(i) Each medical triage facility shall have written agreements for the provision of the following:

- (a) Laboratory services,
- (b) Referral to other levels of care or treatment

(ii) Each facility providing services shall have written transfer agreements with a facility(s) to provide for clients continued participation in the care giving process when indicated.

(H) Each residential detoxification and evaluation, ambulatory detoxification, chemical maintenance treatment facility which admits persons whose substances of abuse is other than alcohol, shall have a provision for regular monitoring of chemical levels in urine specimens collected from clients.

(I) Documentation of a written agreement maintained with a licensed laboratory for the purpose of performing the required urine screenings.

(J) Adoption and review of an emergency preparedness plan.

(g) **Executive Director**

(1) Each facility shall have an executive director who is accountable to the governing authority.

(2) The executive director shall be responsible for the management of the facility.

(h) **Fiscal Management**

(1) Each facility shall have an individual with the designated responsibility for fiscal affairs.

(2) Each facility shall develop and implement written policies and procedures governing the fiscal operation which shall include:

(A) An annual written budget which shall have documentation of review and approval by the governing authority.

(B) Identification of revenues by source and expenditures by service component.

(C) Identification of the fiscal year.

(D) Documentation of an annual audit by an independent public accountant.

(i) **Personnel Practices**

(1) Each facility shall develop and implement written policies and procedures governing the recruitment, selection, promotion and termination of program staff as well as policies and procedures relating to:

(A) Employee work rules;

(B) Disciplinary action including suspension or dismissal of staff;

(C) Annual job performance evaluation;

(D) Physician documentation of periodic physical examinations which are performed for the purpose of preventing infection or contagion from communicable disease.

(2) Personnel policies shall ensure a provision that the facility shall not discriminate because of race, color, religious creed, age, sex, marital status, national origin, ancestry, present or past history or mental disorder, mental retardation or physical disability, including, but not limited to, blindness in its hiring, termination, or promotion practices.

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(3) Personnel files shall be maintained identifying all personnel, including consultants, and shall be stored in a manner to protect the confidentiality of the employee in accordance with all state or federal laws governing the same. Each file shall contain:

- (A) A written verification of the date of hire and position for which hired;
- (B) A resume, if applicable;
- (C) Verification of credentials of licensed or certified staff;
- (D) Past employment reference checks;
- (E) Documentation of required physical examinations;
- (F) Job performance evaluations, except for consultants;
- (G) Documentation of orientation.

(4) There shall be a written job description for each staff position within the facility which includes:

- (A) Definition of duties to be performed;
- (B) Notation of direct supervision;
- (C) Minimum qualifications;
- (D) Effective and/or revision date.

(5) The facility shall develop and implement written policies and procedures governing the utilization of volunteers which shall include:

- (A) Screening of applicants;
- (B) Training;
- (C) Supervision of activities;
- (D) Responsibilities;
- (E) Limitations as to duties;
- (F) Termination of services;

(G) A provision that volunteers shall not be utilized in place of a staff person required by these regulations.

(6) Staff Development and Orientation

(A) Employees shall receive orientation to all policies and procedures necessary for them to perform duties specified in their job descriptions and provide for the safety of the clients. Changes in these policies and procedures shall be communicated in a manner prescribed by the executive director.

(B) Each facility shall establish and implement a staff development plan.

(C) Each facility shall document staff attendance at inservice or workshops, seminars, etc., with the date, topic discussed, and the presenting person(s).

(j) **Environment**

(1) Physical Plant

(A) The standards established by the following sources for the construction, renovation, alteration, maintenance and licensure of all facilities, as they are amended from time to time, are hereby incorporated and made hereof by reference:

- (i) State of Connecticut Basic Building Codes.
- (ii) State of Connecticut Fire Safety Code.

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(iii) State of Connecticut Public Health Code.

(iv) Local Zoning Codes.

(B) Any facility initially licensed after the effective date of these regulations shall conform to the requirements described herein. Any facility licensed prior to the effective date of these regulations shall comply with construction requirements in effect at the time of licensure, provided however, that if the Department shall determine that a pre-existing non-conformity creates serious risk of harm to clients in the facility, the Department may order such facility to comply with the pertinent portion of Subdivision (1) of Subsection (j) of these regulations. Failure of the facility to comply with a Department order under this Subparagraph shall be grounds for action against the license.

(C) Waiver

(i) The Commissioner or his or her designee, in accordance with the general purposes and intent of these regulations, may waive provisions of subparagraphs (D) and (F) of subdivision (1) of subsection (j) Environment of this section if the Commissioner determines that such waiver would not endanger the life, safety or health of any client. The Commissioner shall have the power to impose conditions which assure the health, safety and welfare of client upon the grant of such waiver, or to revoke such waiver upon a finding that the health, safety, or welfare of any client has been jeopardized.

(ii) Any facility requesting a waiver shall apply in writing to the Department. Such application shall include:

- (a) The specific regulations for which the waiver is requested;
- (b) Reasons for requesting a waiver, including a statement of the type, cost, and degree of hardship that would result to the facility upon enforcement of the regulations;
- (c) The specific relief requested; and
- (d) The duration of time for which the waiver is requested.
- (e) Any documentation which supports the application for waiver.
- (f) The level of care provided;
- (g) The maximum client capacity;
- (h) The impact of a waiver on care provided;
- (i) Alternative policies or procedures proposed.

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

(iv) Any hearing which may be held in conjunction with an application for waiver shall be held in conformance with Chapter 54 of the Connecticut General Statutes and Department regulations.

(D) General

(i) The facility shall be of structurally sound construction, equipped, and operated so as to sustain its safe and sanitary characteristics to prevent or minimize all health and fire hazards in the facility for the protection of clients, personnel and visitors.

(ii) The interior, exterior and grounds of the building shall be maintained in an acceptable state of repair, kept clean, and orderly and free from accumulations of refuse, dilapidated

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structures, or other health hazards.

(iii) The design, construction and furnishings of the clients' living and clinical or rehabilitative service areas shall be sufficient in size to accommodate the changing needs of the clients.

(E) New Facilities, Expansions and Conversions

(i) Notification of new construction, expansions or conversions indicating the proposed use shall be submitted to the State Department of Health Services, 60 days prior to the initiation of construction.

(F) Basic Core Requirements

(i) Site locations shall have unobstructed passage to emergency vehicles.

(ii) Walkways shall be provided for each exit from the building leading to a driveway or street.

(iii) Administration and Public Areas.

The following shall be provided:

(a) Storage space for office equipment, supplies and records.

(b) Each facility shall have a private office in which to conduct client interviews.

(iv) Client bedrooms shall meet the following requirements:

(a) Except in residential detoxification and evaluation and medical triage facilities there shall be no more than 4 single beds per bedroom;

(b) The net minimum room floor area shall be not less than 80 square feet for single bed room and 70 square feet per individual in multi-bed rooms. A variance of this requirement up to 10% of the total square footage shall be permitted if it can be demonstrated that the room configuration results in comfortable accommodation;

(c) Provide a minimum of three (3) feet space between parallel beds in multi-bed rooms;

(d) All client bedrooms shall open to a common corridor or common room which leads to an exit;

(e) No client bedroom shall be located in an attic or basement;

(f) Each client bedroom shall be an outside room with windows devoted to not less than 10% of its floor area, excluding closets;

(g) Windows shall be equipped with insect screening;

(h) No room which opens into the kitchen or necessitates passing through the kitchen to reach any other part of the facility shall be used as a bedroom; except when occupancy is 15 or less beds;

(i) The bedroom furnishings for each client shall include: a single bed with a mattress, three dresser drawers, closet or wardrobe space to hang clothing. One mirror per room shall be provided. In addition, each client in a residential facility, except residential detoxification and evaluation and medical triage facilities, shall be provided a chair and a reading light.

(v) Toilet and Bathing Facilities:

(a) Each facility shall have a lavatory equipped with a toilet, sink, mirror, toilet tissue, soap and single service towels. In a residential facility one toilet shall be provided for every eight persons.

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(b) A minimum of one toilet, one handwashing sink and one bathtub or shower shall be provided on each floor, designated as client sleeping areas.

(c) In each residential facility one shower or bathtub shall be provided for each 10 clients or fraction thereof. An individual enclosure which provides space for private bathing and dressing, shall be available in bathing areas with multiple bathtubs or showers.

(d) All toilet and bathing facilities shall be well lighted, and ventilated to the outside atmosphere, either by means of a window that can be opened, or by exhaust fans.

(vi) Services Areas

Each facility shall provide adequate areas for living, dining and individual or general program functions.

(a) Multi-purpose rooms shall be provided for general meetings, educational and other social purposes. The total area set aside for these purposes shall not be less than 25 square feet per licensed bed capacity.

(b) Dining area(s) sufficient to accommodate all clients shall be provided.

(vii) Laundry Service - Residential Facilities.

(a) If clients are responsible for their own laundry, residential type laundry facilities shall be provided or made accessible in the community.

(b) Facilities which supply towels shall maintain a stock equivalent to two times the capacity of the facility.

(c) Facilities which supply bedding shall provide for each client at least one blanket, one pillow, one pillowcase, one top sheet, one bottom sheet and one mattress pad or plastic covered mattress. Bedding shall be appropriate to weather and climate.

(d) Each facility which does not provide bedding or towels shall make provisions to supply such items to any client who does not have such supplies.

(e) If linen is processed outside of the facility, a soiled linen holding room and a clean linen storage room or area shall be provided.

(viii) Environmental Details

(a) All areas used by clients shall have temperatures of not less than 68° F. during the heating season.

(b) The hot water heating equipment shall have sufficient capacity to supply hot water at the temperature of 110–120° F. at client use taps.

(c) Only central heating or permanently installed electric heating systems shall be used.

(d) All doors to client bathrooms, toilet rooms and bedrooms shall be equipped with hardware which will permit access in an emergency.

(e) Walls, ceilings and floors shall be maintained in a good state of repair and be washable or easily cleanable.

(f) Hot water or steam pipes located in areas accessible to clients shall have adequate protective insulation.

(g) Each building shall be provided with a telephone that is accessible for emergency purposes. Each facility shall have a telephone for client use except in nonresidential facilities.

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

(i) All rooms shall have lighting and all bedrooms, toilet rooms and offices shall have general illumination with a control switch at the entrance to each room.

(j) Items such as drinking fountains, telephone booths, vending machines, and portable equipment shall not reduce the corridor width below the width of three feet.

(k) All doors to bedrooms and doors which are a means of egress from the facility shall be of a swing type.

(l) The minimum width of all doors to rooms accessible to clients, shall be 2'-4" except bathroom doors shall not be less than 2'.

(G) Special Requirement – Medical Triage

(i) In each medical triage service there shall be specified areas to conduct examinations. Such areas shall contain the equipment necessary to conduct such examinations. In addition, there shall be the following minimum equipment:

(a) A suction machine,

(b) Oxygen,

(c) Breatholizer,

(d) Scale,

(e) Lamp,

(f) Ambu bag,

(g) Airways,

(h) In multiple occupancy rooms, privacy screens or curtains,

(i) A washable examination table.

(ii) Each medical triage facility shall have a designated holding room area for clients awaiting proper disposition. This area shall provide for each client:

(a) A single bed with a mattress,

(b) In multiple occupancy rooms, private screens or curtains.

(2) Emergency and Disaster Procedures

(A) Each facility shall develop and implement written policies and procedures governing appropriate intervention in the event of an emergency or disaster. Such procedures shall require:

(i) Orientation to staff, volunteers, in the use of fire extinguishers. Such orientation shall be documented.

(ii) Orientation of all staff, including volunteers, and clients with the written evacuation plan instructions and diagrams for facility exit routes.

(iii) There shall be documentation of staff orientation to emergency and disaster procedures.

(iv) Fire plans shall be posted in conspicuous areas throughout the facility.

(v) Fire drills shall be conducted on a monthly basis, at various times, to provide for four drills per shift each year, for all residential facilities. All fire drills shall be documented.

(vi) Each facility shall develop and implement a written plan for the checking of first

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aid supplies on a monthly basis. The plan shall specify the supplies to be stocked, the required amounts of each supply and title of the staff person(s) responsible for the audit. The facility shall document when first aid supplies are checked.

(vii) Each facility shall have a written emergency preparedness plan which shall include the following:

- (a) Identification and notification of appropriate persons.
- (b) Instructions as to locations and use of emergency equipment and alarm systems.
- (c) Tasks and responsibilities of assigned staff.
- (d) Evacuation routes.
- (e) Procedures for relocation and/or evacuation of clients.
- (f) Transfer of casualties.
- (g) Transfer of records.
- (h) Procedures for maintenance of the care and meal service for clients in a residential facility.

(i) Handling of drugs and biologicals.

(3) Dietary Service Areas – Residential Facilities

(A) Each facility shall have a kitchen area, which shall include space and equipment for storage, preparation, assembling and serving food, cleaning or disposal of dishes and garbage. The following shall apply:

(i) Kitchens shall be separate from other areas and large enough to allow for adequate equipment to prepare and keep food properly.

(ii) No food shall be stored directly on the floor.

(iii) All equipment and appliances shall be installed to permit thorough cleaning of the equipment, the floor and the walls around them. The floor surface shall be of non-absorbent material.

(iv) A dishwashing machine shall be provided in all facilities with ten or more beds. Commercial dishwashing machines shall be provided in any residence with twenty-five or more beds and physically separated from the food preparation areas.

(v) A handwashing sink with a soap dispenser and single service towels shall be provided.

(vi) A covered waste receptacle shall be provided in the kitchen area.

(vii) Dry storage space, for at least a three-day supply of food.

(viii) Functional refrigerators and freezers shall be provided for the storage of food to meet the needs of the clients.

(ix) Trash shall be kept in covered receptacles outside the facility.

(k) **Food Services**

(1) Each residential facility shall have a written plan for the provision of food services.

(2) Each residential facility shall have a dietetic consultation based on individual facility needs at least once a year. Such consultation shall be documented by the dietitian.

(3) Each residential facility shall screen all staff and clients who have access to food preparation areas for infectious and communicable diseases. Persons with known infectious

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or communicable diseases shall be restricted from food preparation areas.

(4) Each residential facility shall have written menus for the minimum of a one week period in advance which includes foods available for breakfast and lunch and a planned dinner. Substitutions in planned menus shall be recorded on the menu in advance whenever possible. Menus and substitutions shall be kept on file for at least a thirty day period.

(5) Menu selection and food preparation shall take into consideration the clients dietary needs.

(6) A minimum of three days supply of staple food shall be maintained at all times.

(7) Food shall be stored, prepared and served at proper temperatures.

(I) Accident or Incident Reports

(1) Classification. All accident or incident reports to the Department shall employ the following classifications of such events:

Class A: One which has resulted in a serious condition or death.

Class B: One which has or may interrupt the services provided by the facility.

(2) Report. The executive director shall report any accident or incident within Class A or B, to the Department, immediately by telephone, to be confirmed by written report within seventy-two hours of said events.

(3) Each written report shall contain the following information:

(A) Date of report and date of event.

(B) Facility classification.

(C) Identification of the individuals affected by the event, including, where available: client identification, age, and status (or name, of employee, visitor, or other), nature of incident, action taken by the facility and disposition.

(D) If the affected individual is or was at the time of the reported event a client of the facility:

(i) Date of admission;

(ii) Current diagnosis, if applicable;

(iii) Physical and mental status prior to the event; and

(iv) Physical and mental status after the event.

(E) The location, nature and brief description of the event.

(F) The name and time of notification of the physician or hospital consulted, if applicable.

(G) The name of any witnesses to the event.

(H) Any other information deemed relevant by the reporting facility.

(I) The signature of the person who prepared the report and of the executive director.

(4) Numbering. Each report shall be identified on each page with a number as follows: The number appearing on the facility license; the last two digits of the calendar year; the sequential number of the report during the calendar year.

(5) The executive director shall submit subsequent reports, if applicable, relevant to any accident or incident.

(6) With respect to any information pertaining to (1) Accident or Incident Reports, the

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Connecticut State Department of Health Services shall comply with all state and federal laws and regulations concerning confidentiality of alcohol and drug abuse client records.

(m) Service Operations

(1) Program Evaluation – All Service Classifications

(A) Each facility shall have established goals and objectives related to the client population served.

(B) Each facility shall establish an annual program evaluation, which will determine the degree to which these goals and objectives are being met. Action taken by the facility, based on this evaluation process, shall be documented.

(2) Client Rights – All Service Classifications

(A) Each client shall be informed of his or her rights relating to the services provided in the language of his or her understanding. A statement that the client has been advised of his or her rights, signed by the client shall be placed in the client's record.

(B) A client shall be informed at the time of admission, in writing, of the criteria for involuntary termination from a facility. In the event that a client is aggrieved by such a dismissal, such client shall have recourse to the mechanism established by the governing authority or management.

(3) Client Records – All Service Classifications

(A) An organized written record for each client shall be maintained which contains current information sufficient for an assessment of need for the provision of appropriate care or treatment services.

(B) Each client record shall contain the following:

(i) The client name and identifier, address, date of birth, telephone number, sex, social security number, and date of admission. In addition, the time of admission to a residential detoxification and evaluation and medical triage facility shall be included.

(ii) Presenting problem(s);

(iii) Documentation of advisement of client rights;

(iv) Social or family background;

(v) Next of kin or other designated individual to be notified in the event of an emergency;

(vi) Results of physical examination inclusive of medical history as required herein;

(vii) Substance abuse history;

(viii) Educational background;

(ix) Employment history;

(x) Referral source summary, if any, to include reason for referral and current medications;

(xi) Legal history, if applicable;

(xii) Releases and notations of release of information.

(xiii) Progress notes which document services provided to the client and progress made toward objectives in accordance with the individualized program plan.

(xiv) Documentation of services as rendered.

(C) Each client record shall contain an individualized program plan, as required herein,

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which must include:

(i) Specific objectives;
(ii) Name of assigned staff person to develop and monitor the individualized program plan;

(iii) Description of the type and frequency of services to be provided;

(D) All entries in the client record shall be typewritten or written in ink by a qualified staff member or consultant and shall be dated, legible, and signed by the person making the entry with his or her position title.

(E) Each individual client record shall contain a current list of all medications and instructions for administration.

(F) Each client record shall contain documentation of the periodic individualized program plan review as required herein. Such documentation shall include the date of the review, person(s) conducting the review and any changes in the individualized program plan as the result of the review.

(G) Each client record shall contain a discharge summary which has been written within fifteen working days of the individual client leaving the program. This summary shall:

(i) Indicate the client's progress towards the established plan;

(ii) Address original reason for referral;

(iii) Describe the type, frequency and duration of treatment or services;

(iv) Specify reasons for discharge and, if appropriate, recommended referral.

(H) Client records shall be stored in a secure manner and shall be accessible only to authorized persons. These records, originals or copies, shall be preserved for at least seven years following discharge.

(I) Each client record shall have documentation, at the time of admission, of an initial assessment which identifies the client's appropriateness for participation in the facility.

(4) Admissions, Discharges, and Referrals – All Service Classifications

Each facility shall develop and implement written policies and procedures governing admissions, discharges, and referrals. Such policies shall include:

(A) Identification of the target population.

(B) Criteria for admission.

(C) Criteria for readmission.

(D) The admission process.

(E) Criteria for voluntary and involuntary discharge.

(f) Referrals.

(5) Physical Examinations

(A) Residential Detoxification and Evaluation, Chemical Maintenance, and Ambulatory Chemical Detoxification Facilities.

(i) Each client shall receive within 24 hours of admission a medical history and physical examination, by a physician, physician's assistant or registered nurse practitioner. Any physical examination that is performed by a physician assistant or registered nurse practitioner shall be dated and countersigned by a physician within 72 hours signifying his

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or her review of and concurrence with the findings.

(ii) Each client shall receive within 72 hours of admission, diagnostic tests as determined by the physician.

(iii) Each client whose substance of abuse is other than alcohol shall be required to have an initial drug-screening urinalysis upon admission and at least eight additional random urinalyses' shall be performed on each client during the first year while in a maintenance program. A minimum of quarterly random urinalysis shall be performed on each client while that client is in a maintenance program for more than one year.

(a) Urine specimens must be collected on a randomly scheduled basis and in a manner that minimizes falsification.

(b) Each urine specimen screened is required to be analyzed for opiates, methadone, amphetamines, cocaine and barbiturates as well as other drugs as indicated.

(iv) When a person is readmitted within six months to a facility the decision determining the physical examination, laboratory, and diagnostic tests to be performed shall be made by the program physician.

(v) Any person readmitted to the facility after a six month period of time, shall receive a physical examination and laboratory and diagnostic tests as required in subparagraphs (i), (ii), and (iii) of subsection (5) (A).

(B) Medical Triage Facilities

(i) Each client received shall have a physical examination performed by a physician, physician's assistant or registered nurse at the time of acceptance for triage. The examination shall include the following:

(a) Investigation of the organ systems for possibilities of infectious disease, pulmonary, liver, cardiac abnormalities, dermatologic sequelae of addiction and possible concurrent surgical problems;

(b) Determination of the client's vital signs, examination of the general condition including head, ears, eyes, nose, throat (thyroid), chest (heart, lungs and breasts), abdomen, extremities, skin and neurological assessment and the overall impression of the client.

(c) Laboratory tests as appropriate.

(C) Intensive Treatment, Intermediate and Long Term Treatment and Rehabilitation and Care and Rehabilitation Facilities

(i) Each client shall have a documented physical examination, performed by a physician licensed in the State of Connecticut, physician's assistant or registered nurse practitioner not more than one month prior to or an appointment scheduled not later than five days after admission. Any client receiving uninterrupted treatment or care in a licensed facility shall require only the documentation of the initial physical examination.

(6) Individualized Program Plan – All Services Classifications

(A) An individualized program plan based on the client's needs shall be initiated at the time of admission and reviewed as follows:

(i) Each facility providing care and rehabilitation, intermediate and long term treatment and rehabilitation, outpatient treatment, day or evening treatment and chemical maintenance

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treatment shall review the individualized program plan no later than thirty calendar days after admission.

(a) Intermediate and Long Term Treatment and Rehabilitation, and Day or Evening Treatment

(1) Each individualized program plan shall be reviewed at least every sixty calendar days after the initial thirty day review.

(b) Care and Rehabilitation and Chemical Maintenance

(1) Each individualized program plan shall be reviewed every ninety calendar days after the initial thirty day review for the first year and at least every one hundred eighty calendar days thereafter.

(ii) Each residential detoxification and evaluation, medical triage facility or ambulatory chemical detoxification facility shall modify the individual program plan as needed until the client is discharged.

(iii) Each facility providing outpatient treatment shall review the individualized program plan sixty days after the initial thirty day review and at least every ninety calendar days thereafter.

(iv) Each chemical maintenance treatment facility shall rewrite the individualized program plan every two years.

(v) Each intensive treatment facility shall review the individualized program plan on a weekly basis.

(7) Staffing—All Service Classifications

(A) Each facility shall have individuals, who meet the qualifications as described in the facility's job descriptions and who comply with all mandated state and federal laws, to meet the needs of the clients and the programs or services the facility proposes to deliver.

(B) The services of a consultant may be utilized where applicable to meet the special needs of the facility or clients.

(C) Each facility shall have a designated individual or individuals to provide clinical supervision.

(D) Each facility which provides residential services shall have at least, one direct care staff person in each building, when a client is known to be present and who shall have immediate access to back up staff, for urgent or emergency situations.

(E) Special Requirements—Medical Triage

(i) A physician, who is currently licensed in the State of Connecticut, shall be designated to direct the medical services of the facility. Such a physician shall have experience or training in providing services for substance dependent persons.

(ii) A physician, currently licensed in the State of Connecticut, shall be on call and physically available within 20 minutes during those hours when a physician is not physically present.

(iii) A registered nurse, who is currently licensed in the State of Connecticut, shall be designated to direct nursing services. Such a registered nurse shall have experience or training in providing services for substance dependent persons.

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(iv) There shall be on duty at all times at least one registered nurse who is currently licensed in the State of Connecticut. In each separate medical triage unit there shall be at all times a licensed nurse and other direct care staff to meet the needs of the clients.

(v) Where there are other care or treatment services provided, assignments shall clearly designate the service to which staff are assigned.

(vi) There shall be a pharmacist, currently licensed in the State of Connecticut, who shall be responsible for the supervision of the pharmaceutical services.

(F) Special Requirements—Residential Detoxification and Evaluation Facilities

(i) A physician, who is currently licensed in the State of Connecticut, shall be designated to direct the medical services of the facility. Such a physician shall have experience or training in providing services for substance dependent persons.

(ii) A physician, currently licensed in the State of Connecticut, shall be on-call during those hours when a physician is not physically present.

(iii) a registered nurse, who is currently licensed in the State of Connecticut, shall be designated to direct the nursing services of the facility. Such a registered nurse shall have experience or training in providing services for substance dependent persons.

(iv) There shall be on each shift at least one registered nurse who is currently licensed in the State of Connecticut. In each separate residential detoxification and evaluation unit there shall be at all times a licensed nurse and other direct care staff on duty to meet the needs of the clients.

(v) There shall be a physician, currently licensed in the State of Connecticut and who is eligible to be certified by the American Board of Psychiatry and Neurology; or, a clinical psychologist, currently licensed in the State of Connecticut, to provide psychological evaluation and treatment when necessary.

(vi) There shall be a pharmacist, currently licensed in the State of Connecticut, who shall be responsible for the supervision of the pharmaceutical services.

(G) Special Requirements—Intensive Treatment Facilities

(i) There shall be a physician, licensed in the State of Connecticut, and who is eligible to be certified by the American Board of Psychiatry and Neurology to provide psychiatric diagnosis or treatment when necessary, or, a psychologist currently licensed in the State of Connecticut to provide psychological evaluation and treatment when necessary.

(H) Special Requirements—Chemical Maintenance Treatment and Ambulatory Chemical Detoxification Treatment Facilities

(i) A physician, who is currently licensed in the State of Connecticut, shall be designated to direct the medical services of the facility. Such a physician shall have experience or training in providing services for substance dependent persons.

(ii) There shall be at least one nurse, currently licensed in the State of Connecticut, on duty during medication administration hours. Such a nurse shall have experience or training in providing services for substance dependent persons.

(iii) There shall be a physician, currently licensed in the State of Connecticut and who is eligible to be certified by the American Board of Psychiatry and Neurology to provide

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psychiatric diagnosis or treatment when necessary; or, a psychologist, currently licensed in the State of Connecticut, to provide psychological evaluation and treatment when necessary.

(iv) There shall be a pharmacist, currently licensed in the State of Connecticut, who shall be responsible for the supervision of the pharmaceutical services.

(I) Special Requirement—Residential Detoxification and Evaluation, Chemical Maintenance or Ambulatory Chemical Detoxification and Medical Triage Facilities

(i) Each facility providing services shall develop and implement written policies and procedures protecting against the diversion of controlled substances within the program.

(ii) Each facility providing services shall develop and implement written policies and procedures concerning the transfer of controlled substances and alcohol from visitors to clients.

(8) Special Requirement—Care and Rehabilitation Facilities

(i) Each facility shall develop and implement written policies and procedures governing work therapy.

(9) Pharmaceutical Services—All Service Classifications Which Dispense or Administer Medications

(A) Each facility which utilizes medication as an integral part of treatment shall provide pharmaceutical services to meet the needs of the clients.

(i) The pharmaceutical services shall be conducted in accordance with all applicable federal and state laws and regulations.

(ii) Drug dispensing functions shall be provided through:

(a) A community pharmacy; or

(b) An institutional pharmacy or pharmacist's drug room operated by the facility.

(B) If the facility maintains a pharmacist's drug room, a pharmacist:

(i) Shall be responsible for the control of all bulk drugs and maintain records of their receipt and disposition.

(ii) Shall compound, dispense or distribute all drugs from the drug room.

(iii) Shall monitor the service to ensure its accuracy.

(C) The pharmaceutical services shall be under the supervision of a pharmacist.

(i) If the facility operates an institutional pharmacy, the pharmacist shall be responsible for developing, supervising, and coordinating all activities of the service.

(ii) When pharmaceutical services are obtained through a community pharmacy, the facility shall have a written agreement with a licensed pharmacist to serve as a consultant on pharmaceutical services.

(a) The consultant pharmacist shall visit the facility at least monthly, to review the pharmaceutical services, make recommendations for improvements and monitor the services to ensure its accuracy.

(b) Signed dated reports for each pharmacist's on-site visits with the findings and recommendations shall be kept on file in the facility.

(D) A pharmacist shall be responsible for:

(i) Developing procedures for the distribution and controls of drugs and biologicals in

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the facility.

(ii) Compounding, packaging, labeling and dispensing all drugs to be administered to clients.

(iii) Monitoring drug therapy for drug interactions and incompatibilities and documentation of the same.

(iv) Inspecting all areas where drugs are stored (including emergency supplies) to assure that all drugs are properly labeled, stored and controlled.

(E) The facility in consultation with the pharmacist shall develop and implement written policies and procedures for control and accountability, distribution, and assurance of quality of all drugs and biologicals.

(i) Records shall be maintained for all transactions of pharmaceutical services as required by law and as necessary to maintain control of, and accountability for, all drugs and pharmaceutical supplies.

(ii) Drugs shall be distributed in the facility in accordance with an established procedure which shall include the following requirements:

(a) All drugs shall be dispensed to clients on an individual basis except for predetermined floor stock medication.

(b) Floor stock shall be limited to emergency drugs, contingency supplies of legend drugs needed to maintain clients during detoxification and chemical maintenance and to initiate new therapy, and routinely used non-legend drugs.

(c) Emergency drugs shall be readily available in a designated location(s).

(iii) Drugs and biologicals shall be stored under conditions which assure security and environmental control at all storage locations.

(a) Drugs shall be accessible only to persons who are legally authorized to dispense or administer drugs and shall be kept in locked storage at any time such a legally authorized person is not in attendance.

(b) All drugs requiring refrigeration shall be stored separately in a refrigerator used exclusively for medication which is locked or in a locked room.

(c) The inside temperature of a refrigerator in which drugs are stored shall be maintained within a 36° F to 46° F range.

(iv) Drugs shall be packaged in containers which meet the requirements of the United States Pharmacopeia for adequate protection from light and moisture.

(a) Drugs to be dispensed to clients shall be packaged in accordance with provisions of the poison prevention packaging act.

(v) Drugs and biologicals shall be properly labeled:

(a) The label for containers of medication dispensed from an institutional pharmacy or pharmacist's drug room for floor stock use shall include as a minimum the following information:

(1) Name and strength of the medication.

(2) The expiration date.

(3) The lot or control number.

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(b) The label for containers of medication dispensed from an institutional pharmacy or pharmacist's drug room for inpatient use shall include as a minimum the following information:

- (1) Name of the client.
- (2) Name of the prescribing practitioner.
- (3) Name and strength of drug dispensed.
- (4) Lot number and expiration date.

(c) The label of containers of medication dispensed from a community pharmacy for inpatient use shall as a minimum include the following information:

- (1) Name, address, and telephone number of the dispensing pharmacy.
- (2) Name of the client.
- (3) Name of the prescribing practitioner.
- (4) Specific directions for use.
- (5) Name, strength, and quantity of drug dispensed.
- (6) Date of dispensing the medication.
- (7) Expiration date.

(d) The label for containers of medication dispensed for outpatient use shall as a minimum include the following information:

- (1) Name, address, and telephone number of the dispensing pharmacy or facility.
- (2) Name of the client.
- (3) Name of the prescribing practitioner.
- (4) Specific directions for use.
- (5) Name, strength, and quantity of the drug dispensed (unless contraindicated).
- (6) Date of dispensing the medication.

(vi) Drugs which are outdated, visibly deteriorated, unlabeled, inadequately labeled, discontinued, or obsolete shall be disposed in accordance with an established procedure which includes the following requirements:

(a) Controlled substances shall be disposed of in accordance with Section 21a-262-3 of the Regulations of Connecticut State Agencies.

(b) Non-controlled substances and devices shall be destroyed on the premises by a licensed nurse or pharmacist in the presence of another staff person, in a safe manner so as to render the drugs and devices non-recoverable. The facility shall maintain a record of any such destructions.

(vii) Pharmaceutical reference material shall be maintained in order to provide the professional staff with comprehensive information concerning drugs.

(F) Facilities shall be provided for the storage, safeguarding, preparation, dispensing, and administration of drugs.

(i) Any storage or medication administration area shall serve clean functions only and shall be well illuminated and ventilated. When any mobile drug storage cabinet is not being used in the administration of medicines to clients, it shall be stored in a room which meets this requirement.

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(ii) When there is an institutional pharmacy:

(a) Special locked and ventilated storage space shall be provided to meet the legal requirements for storage of controlled substances, flammable fluids and other prescription drugs.

(b) The premises shall be kept clean, lighted and ventilated, and the equipment and facilities necessary for compounding, manufacturing and/or dispensing drugs shall be maintained in good operational condition.

(G) There shall be written policies and procedures, approved by the medical staff, for the safe prescribing and administration of drugs, and the recording of medication administration.

(i) Medication shall be administered only upon written and signed orders of a practitioner acting within the scope of a license.

(a) Verbal orders for medications or treatment shall be taken only by personnel authorized by law. The order shall include the date, time, and full signature of the person taking the order and shall be countersigned by the practitioner within 48 hours.

(b) Medications not specifically prescribed as to time or number of doses shall be stopped in accordance with an automatic stop order policy.

(ii) Drugs shall be administered directly by a practitioner, physician assistant or by a licensed nurse.

(a) Except that the self-administration of medication by clients may be permitted on a specific written order by the physician. Self-administered medications shall be dispensed, stored, monitored and recorded in accordance with an established procedure.

(b) When intravenous medications are administered by nurses, they shall be administered only by registered nurses who have specific training and clinical experience in the field of intravenous therapy.

(iii) An individual medication record shall be maintained for all clients.

(a) All administered, refused or omitted medication shall be recorded on the client's medication record by the individual responsible for administering the medication.

(b) Medications given on a "as needed" basis shall be recorded on the client's medication record and a corresponding entry made in the nurses' notes indicating the following additional information:

(1) The client's subjective symptoms or complaints.

(2) The time, dose, route of administration, and, if appropriate, the injection site.

(3) The results of the medication given.

(4) The nurse's signature.

(c) Medication treatments shall be recorded in the client's record.

(iv) Medications administered by the physician shall be recorded in the client's record in accordance with procedures established in the facility.

(v) Medication error and apparent adverse drug reactions shall be recorded in the client's medical record, reported to the attending physician and to the nurse supervisor and pharmacist, as appropriate, and described in a full incident report.

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(10) Alternate Medication Systems—All Service Classifications Which Do Not Dispense or Administer Medication

(A) Each facility which utilizes a self-administration or supervised self-administration of medications system shall develop and implement written policies and procedures governing medications as they relate to the services provided. Such policies and procedure shall include:

- (i) Identification of the system to be utilized;
- (ii) Method of obtaining prescription medications;
- (iii) Storage of medications;
- (iv) Establishment of reasonable controls and/or monitoring methods necessary to assure the safety of all clients.

(v) Disposal of unused medication and documentation of the method of destruction of controlled and uncontrolled substances.

(vi) A provision for staff education related to medication. At a minimum this shall be conducted on a semi-annual basis.

(B) Facilities which utilize a supervised self-administration of medication program shall provide for the following:

- (i) Central, non-portable locked storage areas.
- (ii) A list of staff members authorized to supervise the self-administration of medications.
- (iii) Supervision of self-administration of medication shall be witnessed and documented in the client record after each dose.

(11) Restraints

(A) Residential Detoxification and Evaluation and Medical Triage Facilities

(i) Physical restraints shall be utilized only when there is imminent danger to the client or others and when other alternatives have not been successful or are not applicable.

(ii) No client shall be placed in a physical restraint without a physician's order.

(iii) A client in restraint must be kept under constant visual observation by staff and cannot be kept restrained for more than one hour at any one time. If there is not sufficient change in the behavior of the client after an initial three hour period, efforts must be initiated to transfer the client to a general hospital or to a psychiatric hospital for evaluation.

(B) Monitoring

(i) The facility shall develop and implement written procedures for the utilization of restraints which shall include:

- (a) Staff assignment to observe and monitor the restrained client.
- (b) Documentation of the staff member's visual observation and assessment of the client while in restraints.

(c) A provision requiring that the physician's order shall specify the type of restraint to be utilized and the duration of restraint.

(d) A provision requiring that the restraints shall be applied in such a manner as to provide for proper body alignment.

(e) A provision requiring that each client in restraints shall be offered fluids unless

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restricted by a physician's order, and toileting every hour.

(f) A provision requiring that each client in restraints shall receive active or passive range of motion, repositioning and skin care every 30 minutes.

(g) A provision requiring that each client in restraints shall be assessed by a licensed nurse every 30 minutes. Such observation and assessment shall be documented and shall include:

- (1) Blood pressure;
- (2) Pulse;
- (3) Respiration;
- (4) Condition of skin under restraints;
- (5) Evidence of circulatory impairment such as discoloration, change in temperature, edema, numbness and tingling, etc.

(6) Each client in restraints shall be afforded privacy.

(n) **Computerized Medication Administration Systems and Computerized Records**

(1) Licensed private freestanding facilities for the care or the treatment of substance abusive or dependent persons may use computerized systems to maintain an organized record for each client and for the administration of medications.

(2) Notwithstanding subsections (m) (9) (A) (ii) (b) and (m) (9) (B) (ii) of this section, facilities utilizing computerized systems to maintain client records or for medication administration shall be in compliance with this section.

(3) Entries in client records shall be made only by individuals who are authorized to access and make entries in the client records as specified in facility policies and procedures.

(4) For the purpose of this subsection, all entries in client records shall be signed in writing or electronically or initialed by the person making the entry.

(5) Facilities utilizing computerized systems to maintain client records or for medication administration shall develop policies and procedures that shall include, but not necessarily be limited to:

(A) operation and maintenance of the system to include a back up plan in the event that the computer system is not functioning;

(B) required contents of computerized client records; and

(C) a plan for producing printed copies of computerized client records, which shall be maintained in accordance with subsection (m) (3) (H) of this section, at least once every seven (7) days.

(6) All client information shall be maintained in a secure and confidential manner. Policies and procedures shall be developed to address the following:

(A) Unauthorized access to computerized systems shall be protected by use of confidential codes or electronic identifiers in accordance with Section 21a-244a of the Connecticut General Statutes and regulations that may be adopted thereunder.

(B) Entries that require countersigning by a practitioner shall be countersigned in accordance with Subsection (a) of Section 21a-251 of the Connecticut General Statutes

(C) Each system user shall sign a commitment to maintain the confidentiality of their personal identifier, to prevent unauthorized access to their identifier and client records and

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to ensure authenticity of record entry validity.

(D) Facility staff shall be restricted to system use for only those portions of the computerized client information that are essential to perform their professional duties as assigned.

(7) A licensed health care practitioner who administers medication from a computerized medication administration system shall, in the case of liquid forms of medication, visually monitor the dosage.

(8) Use of computerized administration systems shall be restricted to facility staff members and health care practitioners who have documented evidence of successfully completing a comprehensive training program in the use of computerized administration systems, and who have documented evidence of demonstrated competency in the use of the system.

(9) The facility shall establish a quality assurance program to address the use of computerized systems for the maintenance of client records and the administration of medication. The quality assurance program shall include, but not necessarily be limited to, monitoring compliance with all policies and procedures for the use of such systems.

(10) The facility shall provide the department with unrestricted access to client records and records of medication dispensing and administration maintained within the computerized systems.

(11) Prior to the implementation of a computerized system for the dispensing of medications, the licensee shall submit, in writing, authorization from the Department of Consumer Protection for the system.

(o) Auricular Acupuncture

(1) Private Freestanding Facilities for the Care or Treatment of Substance Abusive or Dependent Persons may utilize auricular acupuncture for substance abuse treatment.

(2) The department shall approve an organization to provide training for substance abuse acupuncture specialists in auricular acupuncture if the organization's curriculum meets the requirements listed in subdivision (4) of this subsection. Application for approval shall be made on forms provided by the department. The organization shall maintain records on substance abuse acupuncture specialists who successfully complete a training program that meets or exceeds the requirements listed in subdivision (4) of this subsection and receive certification from the organization.

(3) Prior to performing auricular acupuncture, a person who is not licensed as an acupuncturist shall be trained by a licensed acupuncturist or a substance abuse auricular acupuncture trainer, affiliated with an organization approved by the department. Such person shall receive from an organization approved by the department, written certification that he has successfully completed training to perform substance abuse auricular acupuncture as a substance abuse acupuncture specialist.

(4) The training in auricular acupuncture shall be at least seventy (70) hours in length, shall be a clinical, apprentice based program, and shall include, but not be limited to, the following:

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- (A) objectives;
 - (B) the theoretical basis of auricular acupuncture;
 - (C) the ethical principles that guide the practice of auricular acupuncture detoxification specialists;
 - (D) the evaluation of the effectiveness of treatment;
 - (E) case studies and research;
 - (F) patient counseling, education, and selection criteria, counter indications, and techniques;
 - (G) appropriate protocol, including:
 - (i) preparation of the setting and supplies, including sterilization of needles;
 - (ii) universal precautions;
 - (iii) counseling strategies;
 - (iv) the use of urine testing;
 - (v) data collection and record keeping;
 - (vi) liaisons with other agencies or programs; and
 - (vii) disposal of infectious waste.
 - (H) the relationship of auricular acupuncture to the overall treatment plan of individuals at various stages of rehabilitation;
 - (I) observations of the treatment process, including patient interviews;
 - (J) demonstration of auricular acupuncture techniques by the trainer, and return demonstration of techniques by the trainee;
 - (K) an understanding of the limitations of auricular acupuncture, and that the trainee has been trained to perform auricular acupuncture only in relation to the treatment of substance abuse and not any other type of treatment; and
 - (L) procedures for handling medical emergencies.
- (5) A copy of the current certification documentation from the trainer or the approved organization for each person performing auricular acupuncture shall be on file at the facility where auricular acupuncture is being practiced, and available for review by the department upon request.
- The certification documentation shall include the following information:
- (A) the name of the organization, approved by the commissioner under which the certification is issued;
 - (B) the full name, signature, title, license number (when applicable), address and telephone number of the person who gave the training;
 - (C) the location and date the training was given;
 - (D) a statement that the required curriculum areas listed in subdivision (4) of this subsection were successfully mastered;
 - (E) the name, address and telephone number of the person who completed the training successfully; and
 - (F) the expiration date of the approval.
- (6) The trainee shall obtain from the trainer or the approved organization an outline of

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the curriculum content which verifies that all mandated requirements have been included in the training program. A copy of said outline shall be on file at the facility where the trainee is employed for department review. The department may require at any time that the facility obtain the full curriculum from the trainer or the approved organization for review by the department.

(7) Auricular acupuncture shall be conducted under the supervision of a physician. A written agreement with the supervising physician shall be maintained which includes at least the following provisions:

(A) The supervising physician shall be on call and physically available within twenty (20) minutes during those hours when he is not physically present at the facility.

(B) The supervising physician shall be notified immediately if a medical emergency occurs during auricular acupuncture treatment, by the person performing the procedure.

(C) The supervising physician shall document a review of the auricular acupuncture program which includes treatment observation and client record reviews with recommendations as appropriate. Such reviews shall be conducted at least once every three months. The reports of the supervising physician's reviews shall be maintained on file at the facility for not less than two years.

(8) Each facility that elects to use auricular acupuncture shall make educational material on the procedure available to clients and shall offer auricular acupuncture as an adjunct therapy to all interested clients.

(9) Each facility that elects to use auricular acupuncture shall develop policies that include, but are not limited to:

(A) universal precaution standards;

(B) infection control standards that include employees' risk of exposure and vaccination availability;

(C) provisions for hazardous biomedical waste disposal;

(D) provisions for restricting auricular acupuncture to substance abuse and dependency treatment;

(E) contraindications or precautions regarding the use of auricular acupuncture;

(F) integration of auricular acupuncture with other substance abuse treatment modalities;

(G) auricular acupuncture detoxification treatment;

(H) auricular acupuncture rehabilitation treatment;

(I) maintenance of a needle use log and a lost needle log; and

(J) documentation of related accidents or incidents and reportable diseases.

(10) Each facility that elects to use auricular acupuncture shall develop procedures that include the following:

(A) client indication or contraindication assessment;

(B) specification of auricular acupuncture points to be used for substance abuse treatment;

(C) proper handwashing technique;

(D) prohibition of contact between the substance abuse acupuncture specialist and the

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client that could result in the exchange of body fluid during the procedure;

(E) preparation of the client for treatment by cleansing the external ear with an antiseptic solution;

(F) visual examination of the client's ear for signs of infection or inflammation;

(G) the use of sterile needles for all needle insertions;

(H) compliance with autoclaving sterilization standards, as identified in the most recent edition of standards by the American Operating Room Nurse Association, when nondisposable needles are used;

(I) identification of the procedure duration, extraction and proper disposal of contaminated needles;

(J) a provision that clients are encouraged to remove their own needles;

(K) a provision that all necessary supplies are readily available during the procedure;

(L) the use of containers that safely store sharps;

(M) documentation of all employee needle stick injuries and blood exposures occurring during procedures, such record to be maintained for not less than three years; and

(N) the use of a physician to evaluate all employee needle stick injuries and blood exposures.

(11) Records of clients receiving auricular acupuncture shall contain the following:

(A) an assessment of the indication for the provision of auricular acupuncture;

(B) informed consent signed by the client, or the client's parent or guardian if the client is a minor, and witnessed by a staff counselor;

(C) a written order signed by a physician;

(D) inclusion of auricular acupuncture on the individual program plan as identified in subsection (m)(3)(c) of this section; and

(E) documentation of the treatment provided and response to treatment.

(12) Each facility that elects to use auricular acupuncture shall provide inservice education for staff, at least once every six months, on infection control issues. Such training shall be documented and kept on file at the facility for not less than two years.

(13) Each facility that elects to use auricular acupuncture shall maintain a program for quality assurance that includes, but is not limited to, infection prevention, surveillance and monitoring of adverse reactions and monitoring compliance with policies and procedures for auricular acupuncture.

(Effective June 25, 1990; Amended September 25, 1996; Amended October 30, 1998; Amended April 29, 1999)

Licensure of Recovery Care Centers and Standards For In-hospital Recovery Care Centers

Sec. 19a-495-571. Licensure of recovery care centers and standards for In-Hospital Recovery Care Centers.

(a) **Definitions.** As used in this section:

(1) "Administer" means to initiate the venipuncture and deliver an IV fluid, IV

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admixture, blood and blood components into the blood stream via a vein; monitor the patient; care for the venipuncture site; terminate the procedure; and record pertinent events and observations.

(2) “Care partner” means an individual whose intent is to help the patient in his or her recovery. A care partner may provide assistance with personal care and routine needs.

(3) “Commissioner” means the Commissioner of the Department of Public Health and Addiction Services, or his or her designee.

(4) “Community pharmacy” means a pharmacy licensed pursuant to Section 20-168 of the Connecticut General Statutes. An exception may be made for those cases in which a specific patient has a third party prescription drug plan that requires the patient to obtain medications from a specific pharmacy located outside the State of Connecticut, provided such pharmacy complies with the requirements of the State of Connecticut regulations and the policy of the facility regarding labeling and packaging.

(5) “Department” means the Connecticut Department of Public Health and Addiction Services.

(6) “IV admixture” means an IV fluid to which one or more additional drug products have been added.

(7) “IV fluid” means sterile solutions intended for intravenous infusion.

(8) “IV therapy” means the introduction of an IV fluid or IV admixture into the blood stream via a vein for the purpose of correcting water deficit and electrolyte imbalances, providing nutrition, and delivering antibiotics and other therapeutic agents approved by the facility’s medical staff. “IV Therapy” also means the introduction of blood and blood components into the blood stream via a vein.

(9) “IV therapy nurse” means a registered nurse who is qualified by education and training and has demonstrated proficiency in the theoretical and clinical aspects of IV therapy to administer an IV fluid, IV admixture, blood and blood components.

(10) “IV therapy trainer” means a registered nurse who has been certified in IV Therapeutics by the National Intravenous Therapy Association and possesses current certification from that entity.

(11) “IV therapy program” means the overall plan by which the facility shall implement, monitor and safeguard the administration of IV therapy to patients.

(12) “Life support system” as defined in section 19a-570 (1) of the Connecticut General Statutes means any medical procedure or intervention which, when applied to an individual, would serve only to postpone the moment of death or maintain the individual in a state of permanent unconsciousness. In these circumstances, such procedures shall include, but are not necessarily limited to, mechanical or electronic devices including artificial means of providing nutrition or hydration.

(13) “Nurse’s aides” means unlicensed workers employed and trained to assist licensed nursing personnel and entered on the nurse’s aide registry maintained by the department.

(14) “Practitioner” means a physician, dentist or other person authorized to prescribe drugs in the course of professional service in the State of Connecticut.

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(15) “Qualified social work consultant” means a person who possesses at least a master’s degree in social work from a college or university that was accredited by the Council on Social Work Education at the time of his or her graduation, and has at least two (2) years of post graduate social work experience in a health care setting.

(16) “Qualified social worker” means a person who possesses at least a bachelor’s degree in social work from a college or university that was accredited by the Council on Social Work Education at the time of his or her graduation, and has at least one (1) year of post degree social work experience in a health care setting.

(17) “Recovery care center” or “center” means a center providing care and services to patients following an acute event as a result of illness, injury or exacerbated disease process and who are in need of a high degree of medical direction, but for whom acute-hospitalization is not required.

(A) An in-hospital recovery care center is a special unit of a licensed hospital and must be located attached to or on the grounds of a licensed hospital. Duplication of services is not required if the services are approximate to the point of service as determined by the department.

(B) A recovery care center is a freestanding licensed facility or otherwise specifically designated unit of a licensed facility that shall contain all of the elements for service and function contained in this section.

(18) “Reportable event” means an occurrence, situation or circumstance which is unusual or inconsistent with the policies and practices of the facility.

(19) “Supervision” means the direction, inspection, and on-site observation of the functions and activities of others in the performance of their duties and responsibilities.

(b) Licensure procedure

(1) Application for a separate license to operate a recovery care center may be made only by an existing facility which was operating independently as of July 1, 1994, and that has not been issued a license as a facility under any category in Connecticut General Statutes, Chapter 368v, Section 19a-490.

(2) If it is determined by the appropriate state agency that a certificate of need is required to operate a recovery care center, the certificate of need shall be a prerequisite to licensing or provision of service.

(3) Application for licensure

(A) No person shall operate a recovery care center without a license issued by the department in accordance with Connecticut General Statutes, Section 19a-491.

(B) Application for the grant or renewal of a license to operate a recovery care center shall be made to the department in writing, on forms provided by the department; shall be signed by the person seeking authority to operate the service; shall be notarized; and shall include, but not necessarily be limited to the following information:

(i) names and titles of administrative staff including the administrator, director of nursing services, supervisor or head nurse, medical director or specified physician;

(ii) patient capacity;

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- (iii) total number of employees, by category;
 - (iv) services provided;
 - (v) evidence of financial viability to include a projected two (2) year budget, including estimates of net income and expenditures, at the time of initial application, and balance sheet as of the end of the most recent fiscal year, at the time of license renewal;
 - (vi) certificate of malpractice and public liability insurance;
 - (vii) certificate of good standing, if applicable;
 - (viii) statement of ownership and operation, including, but not necessarily limited to the name and address of each owner and, if the center is a corporation, all ownership interests (direct or indirect) of ten percent (10%) or more and the name and address of each officer, director and member of the governing authority;
 - (ix) relevant statistical information requested by the department;
 - (x) agent for service; and
 - (xi) local fire marshal's annual certificate.
- (C) The recovery care center shall notify the department of any changes in the information provided in accordance with subparagraph (B) of this subdivision.
- (4) Issuance and renewal of license
- (A) Upon determination by the department that the recovery care center is in compliance with the statutes and regulations pertaining to its licensure, the department shall issue a license or renewal of license to operate the center for a period not to exceed two (2) years.
- (B) Application for license renewal shall be made in accordance with subparagraph (B) of subdivision (3) of this subsection and not less than thirty (30) days preceding the date of expiration of the center's current license.
- (C) A license shall be issued in the name of the entity that has submitted application for the license.
- (D) The license shall not be transferable to any other person, entity or service and shall be applicable only to the site for which it is issued.
- (E) Each license shall list on its face, the name of the licensee, the "doing business as" name, the location, and the date of issuance and expiration.
- (F) The license shall be posted in a conspicuous and centrally located place.
- (G) The licensee shall immediately notify the department in writing of any change in administrative personnel of the recovery care center.
- (H) Any change in the ownership of a recovery care center owned by an individual, partnership or association or the change in ownership or beneficial ownership of ten percent (10%) or more of the stock of a corporation that owns or operates such center, shall be subject to prior approval by the department. The licensee shall notify the department in writing of any such proposed change of ownership, at least ninety (90) days prior to the effective date of such proposed change.
- (5) Suspension, revocation, denial, non-renewal or voluntary surrender of license
- (A) A license may be suspended, revoked, denied or its renewal refused whenever in the judgment of the department the center:

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(i) fails to comply with applicable regulations and/or laws prescribed by the commissioner;

(ii) furnishes or makes any false or misleading statements to the department in order to obtain or retain the license; or

(iii) fails to provide the mandatory care services on a continual basis.

(B) In the event of the suspension, revocation, denial or non-renewal of a license, the recovery care center shall be provided the opportunity for a hearing in accordance with the contested case provisions of Chapter 54 of the Connecticut General Statutes and Sections 19a-4-1 through 19a-4-31 of the regulations of Connecticut State Agencies, as applicable.

(C) Refusal to grant the department access to the patient's records, or staff of the center shall be grounds for suspension, revocation, denial or non-renewal of the license.

(D) Surrender of license. The center shall notify, in writing, each patient receiving services from the center, the next of kin or legal representative, and any third party payors concerned, at least fourteen (14) days prior to the voluntary surrender of a recovery care center license or surrender of license upon the department's order of revocation, refusal to renew, or suspension of license. Arrangements shall be made by the licensee for the continuation of care and services as required for patients following the surrender of the center's license.

(c) General conditions for admission

(1) Patients admitted to recovery care centers shall not require intensive care services, coronary care services, or critical care services. Recovery care services do not include surgical services, radiology services, pre-adolescent pediatric services or obstetrical services over twenty-four (24) weeks gestation.

(2) No patient whose condition is documented as terminal, in need of hospice care, below the Rancho Los Amigos Level VI of cognitive functioning or mentally incapable of recognizing that an emergency situation exists shall be admitted to the center.

(3) Admission to the center shall be restricted to patients who fall within the following categories and for whom it is reasonable to expect an uncomplicated recovery:

(A) emergency room procedures that do not require hospitalization;

(B) diagnostic or surgical procedures that do not routinely require hospitalization;

(C) medical, chemical or radiological treatments that are performed on an outpatient basis;

(D) medically stable hospitalized patients who require continued health care services to meet the hospital's discharge criteria (Intensity, Severity and Discharge (ISD-A) Severity of Illness, Intensity of Service Criteria); or

(E) patients requiring post surgical care who have had outpatient surgical procedures performed and who need or desire continued care.

(4) No patients who have had cardiac catheterizations may be admitted to the center with the exception of those patients who meet American College of Cardiology and American Heart Association Guidelines for cardiac catheterization Class I and are deemed stable by a cardiologist, which patients may not be admitted sooner than four (4) hours post cardiac

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catheterization procedure.

(5) No patient shall be admitted to an out-of-hospital recovery care center who requires support services from a hospital or a laboratory to ensure safety and stability of the patient's condition, including, but not necessarily limited to, blood gas monitoring.

(6) Lengths of stay shall be as follows:

(A) Patients admitted from any ambulatory surgical setting shall be limited to an anticipated three (3) day period of time. Patients who unexpectedly exceed a three (3) day period shall require a progress note written by the attending physician that shall justify the unanticipated extended length of stay.

(B) Patients admitted from acute or community settings whose length of stay exceeds a three (3) day period require a progress note written by the attending physician every three (3) days that shall justify the extended length of stay for continuation of treatment.

(C) The length of stay shall not exceed twenty-one (21) days.

(d) **Governing body. Out-of-hospital recovery care centers**

(1) The center shall have a governing body which shall have the general responsibilities to:

(A) set policy;

(B) oversee the management and operation of the facility;

(C) ensure the financial viability of the facility; and

(D) ensure compliance with current standards of practice relative to any practice or procedure performed in the facility or by any professional staff or consultant utilized by the facility.

(2) Specific responsibilities of the governing body necessary to carry out its general duties shall include, but not necessarily be limited to, the following:

(A) adoption and documented annual review of written center and medical staff by-laws;

(B) development of an annual budget;

(C) annual review and update of the center's institutional plan, including anticipated needs, income and expenses;

(D) review of center compliance with established policy;

(E) appointment of an administrator who is qualified in accordance with subsections (e) (1) and (2) of this section;

(F) provision of a safe physical plant equipped and staffed to maintain the center and services;

(G) approval of an organizational chart which establishes clear lines of responsibility and authority in all matters relating to management and maintenance of the center;

(H) determination of the frequency of meetings of the governing body and documentation of such meetings through minutes;

(I) written confirmation of all appointments made or approved by the governing body; and

(J) adoption of a written policy concerning potential conflict of interest on the part of members of the governing body, the administration, medical and nursing staffs and other

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employees who might influence corporate decisions.

(e) **Administrator**

(1) The administrator shall possess a master's degree in a health related field or in administrative studies. If the administrator is a physician, he or she shall also possess an unrestricted license for the practice of medicine in the State of Connecticut.

(2) The administrator shall have two (2) years of administrative experience in a health care facility.

(3) The administrator shall be responsible for the following:

(A) enforcing any applicable local, state and federal laws, and regulations and center by-laws;

(B) appointing, with the approval of the governing body, of a medical director who is qualified under subsection (i) of this section and a director of nursing services who is qualified under subsection (n) of this section;

(C) serving as a liaison between the governing body, medical and nursing staffs, and other professional and supervisory staff;

(D) appointing, in writing, and with the approval of the governing body, a responsible employee to act in his or her behalf in temporary absences;

(E) employing qualified personnel in sufficient numbers to assess and meet patient needs including the provision of orientation and training as necessary, with the advice of the medical director and director of nursing services;

(F) defining the duties and responsibilities of all personnel classifications;

(G) maintaining a patient roster and a daily census of all patients admitted and discharged by the facility which shall be submitted to the department the last day of each quarter unless otherwise requested and shall include but not necessarily be limited to the following information:

(i) admission date, discharge date and length of stay;

(ii) diagnosis;

(iii) type of admission;

(iv) reason for admission;

(v) surgical procedure, if applicable;

(vi) identification of any medical or surgical complication that developed during patient's stay;

(vii) discharge location;

(viii) any other information requested by the department; and

(H) developing a coordinated program for orientation to the center, in-service training and continuing education for all categories of staff in order to develop skills and increase knowledge so as to improve patient care, in cooperation with the medical director and director of nursing services.

(4) The administrator or the administrator's designee for an out-of-hospital recovery care center shall serve no less than twenty (20) hours per week on the premises of the center and shall be on twenty-four (24) hour call for a center of twenty-one (21) or less beds.

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(5) The administrator or the administrator's designee for an out-of-hospital recovery care center shall serve full time on the premises of the center, and shall be on twenty-four (24) hour call, for a center of more than twenty-one (21) beds.

(6) The administrator or the administrator's designee for an in-hospital recovery care center shall serve no less than ten (10) hours per week on the premises of the center and shall provide for twenty-four (24) hour on-call coverage.

(f) Personnel policies for a recovery care center

(1) A recovery care center shall have written personnel policies that shall include but not necessarily be limited to:

(A) documentation that all employees have satisfactorily completed an orientation program appropriate to their job description;

(B) provision of in-service education at least quarterly, with content appropriate to the scope of services provided;

(C) policy and procedure for annual performance evaluations, which includes a process for corrective action when an employee receives an unsatisfactory performance evaluation;

(D) job descriptions;

(E) physician documentation of biennial physical examinations; and

(F) annual tuberculin testing.

(2) For all employees of the recovery care center, the center shall maintain individual personnel records containing at least the following:

(A) an application that contains educational preparation and work experience;

(B) verification of current licensure or certification as appropriate;

(C) written annual performance evaluations;

(D) signed contract or letter of appointment specifying conditions of employment;

(E) record of health examinations; and

(F) documentation of orientation.

(g) **Patients' bill of rights.** A patients' bill of rights shall be implemented for each patient admitted to the center. A notice shall be conspicuously posted on each nursing unit that states the following: "Any complaints regarding care or services may be made to the Department of Public Health and Addiction Services, Hospital and Medical Care Division, 150 Washington Street, Hartford, Connecticut 06106." The bill of rights shall provide that each patient:

(1) is fully informed of these rights, as evidenced by his or her written acknowledgment, prior to or at the time of admission;

(2) is fully informed by a physician of his or her medical condition, unless medically contraindicated as documented by the physician in the medical record, and is afforded the opportunity to participate in the planning of his or her medical treatment and to refuse to participate in experimental research;

(3) may be physically or chemically restrained only to ensure their physical safety and only upon the written order of a physician that specifies the type of restraint and the duration and circumstances under which the restraints are to be used, except in emergencies until a

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specific order can be obtained;

(4) is assured confidential treatment of his or her medical records, and may approve or refuse their release to any individual outside the center, except in case of transfer to another health care institution or as required by law or third-party payment contract;

(5) is advised of the requirements of the Patient Self Determination Act of 1990, P.L. 101-508, section 4206 (a)(2) and section 4751 (a)(2) on advance directives; and

(6) is encouraged and assisted, throughout the length of stay, to exercise his or her rights as a patient and as a citizen, and to this end may voice grievances and recommend changes in policies and services to center staff, free from abuse, restraint, interference, coercion, discrimination or reprisal.

(h) Reportable event(s)

(1) Classification. All reportable events shall be classified as follows:

(A) Class A: an event that has caused or resulted in a patient's death or presents an immediate danger of death or serious harm;

(B) Class B: an event that indicates an outbreak of disease or foodborne outbreaks as defined in section 19a-36-A1 of the regulations of Connecticut State Agencies; a complaint of patient abuse or an event that involves an abusive act to a patient by any person; for the purpose of this classification, abuse means a verbal, mental, sexual, or physical attack on a patient that may include the infliction of injury, unreasonable confinement, intimidation, or punishment;

(C) Class C: an event (including but not limited to loss of emergency electrical generator power, loss of heat, loss of water system) that shall result in the evacuation of one (1) or more patients within or outside of the facility and all fires regardless of whether services are disrupted; or

(D) Class D: an event that has caused or resulted in a serious injury or a significant change in a patient's condition; an event which involves medication error(s) of clinical significance; or an adverse drug reaction of clinical significance which for the purpose of this classification, means an event that adversely alters a patient's mental or physical condition.

(2) All documentation of reportable events shall be maintained at the center for not less than three (3) years.

(3) The administrator or his or her designee shall report any reportable event to the department according to the following schedule:

(A) Classes A, B and C: immediate notice by telephone to the department, to be confirmed by written report as provided herein within seventy-two (72) hours of said event; and

(B) Class D: written report to the department as provided herein within seventy-two (72) hours of said event.

(4) Each written report shall contain the following information:

(A) date of report and date of event;

(B) identification of the patient(s) affected by the event including:

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- (i) name;
- (ii) age;
- (iii) injury;
- (iv) distress or discomfort;
- (v) disposition;
- (vi) date of admission;
- (vii) current diagnosis;
- (viii) physical and mental status prior to the event; and
- (ix) physical and mental status after the event;
- (C) location, nature and brief description of the event;
- (D) name of the physician consulted, if any, time of notification of the physician and a report summarizing any subsequent physical examination, including findings and orders;
- (E) names of any witnesses to the event;
- (F) any other information deemed relevant by the reporting authority or the licensed administrator; and
- (G) signatures of the person who prepared the report and the licensed administrator.

(5) All reportable events that have occurred in the center shall be reviewed on a monthly basis by the administrator and director of nursing services. All situations that have a potential for risk shall be identified. A determination shall be made as to what preventative measures shall be implemented by the center staff. Documentation of such determination shall be submitted to the medical staff. This documentation shall be maintained for not less than three (3) years.

(6) An investigation shall be initiated by the center within twenty-four (24) hours of the discovery of a patient(s) with an injury of suspicious or unknown origin or receipt of an allegation of abuse. The investigation and the findings shall be documented and submitted to the center's medical staff for review. This documentation shall be maintained at the center for a period of not less than three (3) years.

(7) Numbering. Each report shall be identified on each page with a number as follows: the last two (2) digits of the year and the sequential number of the report during the calendar year.

(8) Subsequent reports. The administrator shall submit subsequent reports relevant to any reportable event as often as is necessary to inform the department of significant changes in the status of affected individuals or changes in material facts originally reported. Such reports shall be attached to a photocopy of the original reportable event report.

(i) **Medical director**

(1) The medical director shall be a physician licensed to practice medicine in Connecticut, shall serve on the facility's medical advisory board, shall be board certified in a specialty appropriate to the types of patients being served in the center as specified by the governing body and shall be a member of the medical staff of a general hospital licensed in Connecticut.

(2) The position of medical director shall not be held by the same person who holds the

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position of administrator.

(3) In-hospital recovery care centers shall provide medical direction through the designation of a specified physician in accordance with the hospital medical staff by-laws. A minimum of ten (10) hours a week of medical direction and supervision shall be provided.

(4) The medical director in an out-of-hospital recovery care center shall be appointed by the governing body and shall have the following powers and responsibilities:

(A) enforcing the bylaws governing medical care;

(B) approving or denying applications for membership on the center's medical staff in accordance with subsection (k) of this section;

(C) appointing all physicians by letter of appointment which delineates the physicians' privileges, duties and responsibilities and is acknowledged in writing by the appointee;

(D) in accordance with the medical staff bylaws, suspending or terminating the center privileges of a medical staff member if that member is unable or unwilling to adequately care for a patient in accordance with state statutes, regulations, and standards of practice;

(E) assuring that quality medical care is provided in accordance with quality assurance requirements as established by the center; and

(F) serving as a liaison between the medical staff and administration;

(5) The medical director or his or her designee shall have the following responsibilities:

(A) approving or disapproving a patient's admission based on the center's ability to provide adequate care for the individual in accordance with the medical staff bylaws and subsection (c) of this section by record review or patient examination prior to admission;

(B) assuring that each patient in the center has an assigned personal physician;

(C) providing or arranging for the provision of necessary medical care to the patient if the individual's personal physician is unable or unwilling to do so;

(D) visiting the center daily to assess the adequacy of medical care provided in the center;

(E) providing a minimum of twenty (20) hours a week of medical direction and supervision on-site;

(F) receiving reports from the director of nurses on significant clinical developments; and

(G) documenting visits to the recovery care center which shall minimally include the date and time of the visit, the names of the patients reviewed and a summary of problems discussed with the staff.

(j) **Medical staff and allied health professionals. In-hospital recovery care centers.** In-hospital recovery care center medical staff and allied health professional appointments shall be consistent with the medical staff organization and bylaws.

(k) **Medical staff and allied health professionals.** Out-of-hospital recovery care centers

(1) All members of the medical staff and allied health professionals shall:

(A) possess a full and unrestricted Connecticut license; and

(B) satisfy specific standards and criteria set in the medical bylaws of the center.

(2) All members of the medical staff shall be available by phone twenty-four (24) hours a day, be available to respond promptly in an emergency, and be able to provide an alternate

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physician for coverage whenever necessary.

(3) Each member of the center's medical staff shall sign a statement attesting to the fact that such member has read and understood the center's medical bylaws, policies and procedures, and applicable statutes and regulations, and that such member shall abide by such requirements to the best of his or her ability.

(l) Medical advisory board members. Out-of-hospital recovery care centers

(1) The center shall have a medical advisory board. The medical advisory board shall include no less than five (5) physicians licensed in Connecticut.

(2) The medical advisory board shall meet at least once every ninety (90) days. Minutes shall be maintained for all such meetings with copies sent to all medical staff members. The regular business of the medical advisory board meetings shall include, but not necessarily be limited to, the hearing and consideration of reports and other communications from physicians, the director of nursing services, and other health professionals on:

(A) patient care topics, including all deaths, accidents, complications and infections; and

(B) interdisciplinary care issues including, but not necessarily limited to, nursing, physical therapy, social work and pharmacy.

(3) Medical advisory board members shall attend at least fifty percent (50%) of medical advisory board meetings per year. If two (2) or more members of the medical advisory board are members of the same partnership or incorporated group practice, one (1) member of such an association may fulfill the attendance requirements for the other members of that association provided quorum requirements are met. In such case, the member in attendance shall be entitled to only one (1) vote.

(4) The medical advisory board shall adopt written bylaws governing the medical care of the center's patients. Such bylaws shall be reviewed biennially and approved by the medical director and the governing body. The bylaws shall include, but not necessarily be limited to:

(A) acceptable standards of practice for the medical staff;

(B) criteria and methodology for evaluating the quality of medical care provided in the center;

(C) criteria by which the medical director shall decide the admission or denial of admission of a patient based on the center's ability to provide care which shall specifically define the types of physical and mental disabilities and conditions for which the center intends to provide care and services and which are consistent with the criteria for admission, types of services and diagnostic procedures that shall be performed, types of medical conditions and surgical procedures for which the center shall provide aftercare services, and admission criteria as noted in subsection (c) of this section;

(D) standards for the medical director to grant or deny privileges and to discipline or suspend the privileges of members of the medical staff, including assurance of due process in the event of such actions;

(E) quorum requirements for medical advisory board meetings, provided a quorum may not be less than fifty percent (50%) of the physicians on the medical advisory board;

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(F) specific definition of services, if any, that may be provided by non-physician health professionals such as physician assistants or nurse practitioners;

(G) standards to ensure that members of the medical staff make safe, appropriate and timely referrals to other health care institutions when a patient's condition has changed since admission and said patient can no longer be safely housed in this setting;

(H) standards to ensure that, in the event of the medical director's absence, inability to act, or vacancy of the medical director's office, another physician on the center's medical advisory board is temporarily appointed to serve in that capacity; and

(I) criteria for appointment to the medical advisory board.

(m) **Director of nursing services.** In-hospital recovery care centers. In-hospital recovery care centers shall provide nursing direction through the designation of a specified registered nurse licensed in Connecticut in accordance with nursing standards of practice. This designated person shall serve full time in this capacity.

(n) **Director of nursing services. Out-of-hospital recovery care centers**

(1) The director of nursing services shall be a nurse licensed and registered in Connecticut with a master's degree in nursing and at least two (2) years of experience in medical, surgical or rehabilitative nursing and one (1) year of experience in nursing service administration.

(2) The director of nursing services shall be responsible for the supervision and quality of nursing care provided in the facility. The director of nursing services' responsibilities and duties shall include, but not necessarily be limited to, the following:

(A) development and maintenance of written nursing service standards of practice, to be ratified by the governing body;

(B) development of written job descriptions for nurses and nurse's aides;

(C) development and implementation of a patient acuity system upon which the staffing model shall be based, which shall include, but not necessarily be limited to, the following:

(i) categorization of patient population;

(ii) determination of direct and indirect patient activities and related functions;

(iii) classification of care givers and levels of responsibility; and

(iv) provision of staff replacement time;

(D) development of a methodology to ensure that staffing remains appropriate to the patient population being served;

(E) appointment of nurse supervisors as required to meet the needs of the population served;

(F) coordination and direction of the total planning for nursing services, including recommending to the administrator the number and levels of nurses and nurse's aides to be employed;

(G) assistance in the development of and participation in a staff orientation and training program, in cooperation with the administrator and medical director; and

(H) appointment, with the approval of the administrator, of a nurse employed at the facility to act on behalf of the director of nursing services in temporary absences.

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(3) The director of nursing services shall work forty (40) hours per week.

(o) **Nurse supervisor.** A nurse supervisor shall be a nurse registered and licensed in Connecticut. Nursing supervision shall be provided twenty-four (24) hours a day, seven (7) days a week. The responsibilities of the nurse supervisor shall include:

(1) supervision of nursing activities during his or her shift;

(2) notification of a patient's attending physician if there is a significant change in the condition of the patient or if the patient requires immediate medical care, or notification of the medical director if the patient's personal physician does not respond promptly; and

(3) maintenance of standards of care.

(p) **Nursing staff**

(1) The center shall employ sufficient nurses and nurse's aides to provide appropriate care of patients housed in the center twenty-four (24) hours a day, seven (7) days a week.

(2) There shall be at least two (2) registered nurses on duty from seven (7) a.m. to eleven (11) p.m., seven (7) days a week. From eleven (11) p.m. to seven (7) a.m. there shall be at least one (1) registered nurse on duty. At no time shall there be less than two (2) persons in attendance for patient care.

(3) Nursing staff shall ensure that each patient:

(A) receives treatments, therapies, medications and nourishments as prescribed in the patient care plan;

(B) is clean and comfortable;

(C) is protected from accident, incident, infection, or other unusual occurrence; and

(D) is provided with teaching appropriate to his or her needs.

(4) The nurse supervisor shall report significant clinical developments to the patient's personal physician.

(5) All nursing staff shall be certified in advanced cardiac life support.

(6) All nurse's aides who are employed to provide care and services to patients must be registered with the department.

(q) **Care partners**

(1) The care partner's responsibilities are limited to the following:

(i) acting as an observer in providing information about the patient (such as temperature and appetite) to the nursing staff;

(ii) participating in the patient's educational sessions; and

(iii) being a companion to the patient.

(2) Each care partner shall be provided with all necessary training, supervision and monitoring to ensure that said person performs each activity without risk to the patient or self. This training shall be provided and accordingly documented by qualified personnel.

(r) **Medical and professional services**

(1) Admission procedures. All patients are to be certified by their attending physicians as medically stable prior to admission. Documentation to this effect shall be present in the patient's medical record.

(2) The patient or his or her next of kin or legal representative shall be provided with

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the names of all persons providing professional health care services to the patient.

(3) A method for identification of all patients shall be established and maintained at all times.

(4) Admission documents must include one of the following:

(A) Hospital discharge. The referring physician must complete the hospital's discharge summary and a W-10 form. Both documents must accompany the patient to the center on the day of transfer.

(B) Ambulatory surgery discharge. Copies of the referral history and physical form, anesthesiology record and post-operative instruction sheet must accompany the patient to the center at the time of transfer.

(C) Direct admissions from the community. A comprehensive medical history and medical examination shall be completed for each patient within forty-eight (48) hours prior to admission and must either accompany the patient at the time of admission or must be on file in the center prior to the admission of the patient.

(5) A patient assessment shall be completed by a registered nurse upon admission to the recovery care center.

(A) Post surgical patients shall have a post-surgical assessment that includes physical condition, post-operative status, and deviations from the pre-operative assessment.

(B) Medically stable post-institutional patients shall have physical assessments which verify the discharge summary data and transfer documents from the transferring health care agency.

(C) Admissions directly from home shall have assessments completed by all disciplines to be involved in the care of the patient which shall include, but not necessarily be limited to, health history, physical, mental and social status, evaluation of problems and rehabilitation potential.

(6) A nursing assessment shall be performed upon admission and shall include, but not necessarily be limited to, the following:

(A) temperature, pulse and respiration;

(B) blood pressure;

(C) dressing and cast checks;

(D) status of parenteral fluids or other lines;

(E) respiratory and circulatory state; and

(F) cognitive status.

(7) No medication or treatments shall be given without a physician's order. If orders are given verbally, they shall be recorded by a licensed nurse on duty or professional with statutory authority to receive verbal orders and shall be signed by the physician within twenty-four (24) hours.

(8) Attending physicians shall visit the facility daily to assess the adequacy of medical care rendered to their patients.

(9) Informed consent. It shall be the responsibility of the facility to ensure that, except in emergency situations, the responsible physician shall obtain informed consent as a

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prerequisite to any procedure or treatment and provide evidence of consent by a form signed by the patient.

(10) Standards of practice. Recovery care centers and their staff shall comply with established standards of practice relative to any practice or procedure performed in the center or by any professional staff member or consultant utilized by the center.

(s) Rehabilitation services

(1) Rehabilitation needs shall be met either through services provided directly or through arrangements with outside resources appropriately licensed or certified, upon a physician's written order.

(2) Each rehabilitative service performed shall be recorded in the patient's record and shall be signed and dated by the person providing the service.

(3) Rehabilitation services shall be available a minimum of five (5) days a week and be provided a minimum of three (3) hours a day.

(t) Therapeutic recreation

(1) The recovery care center shall provide therapeutic recreation services as patient needs indicate. An assessment of each patient shall be completed within seven (7) days of admission to identify individual needs or problems to be addressed through therapeutic recreation services.

(2) Services shall be provided on an individual or group level to meet patient needs and to contribute to the overall plan of care.

(u) Personal care services. Provision shall be made for personal care services based on individual patient needs.

(v) Dietary services

(1) The center shall meet the daily nutritional needs of the patients and is responsible to:

(A) provide a diet for each patient, as ordered by the patient's personal physician, based upon current recommended dietary allowances of the Food and Nutrition Board of the National Academy of Sciences, National Research Council, adjusted for age, sex, weight, physical activity, and therapeutic needs of the patient;

(B) adopt a diet manual, as recommended by the center's dietitian or dietary consultant and approved by the center's medical staff which shall be used to plan, order, and prepare regular and therapeutic diets;

(C) employ a food service supervisor who is a dietitian or receives regular monthly consultation from a dietitian who shall supervise the overall operation of the dietary service; and

(D) employ sufficient personnel to carry out the functions of the dietary service and to provide continuous service over a period of twelve (12) hours, which period shall include all mealtimes.

(2) The center shall ensure that the dietary service:

(A) considers the patients' cultural backgrounds, food habits and personal food preferences in the selection of menus and preparation of foods and beverages pursuant to

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subparagraphs (A) and (B) of subdivision (1) of this subsection;

(B) has written and dated menus, approved by a dietitian, planned at least three (3) days in advance;

(C) distributes a menu to each patient;

(D) serves at least three (3) meals, or their equivalent, daily at regular hours;

(E) provides appropriate food substitutes of similar nutritional value to patients who refuse the food served;

(F) provides special equipment, implements or utensils to assist patients while eating, if necessary; and

(G) maintains at least a three (3) day supply of staple foods at all times.

(3) Records of menus served and food purchased shall be maintained for at least thirty (30) days.

(w) **Social work. In-hospital recovery care centers**

(1) Any in-hospital recovery care center, as defined in subsection (a) (17) (A) of this section, must provide a social work services program to the patients of the unit consistent with this section.

(2) If the provision of social work services to the in-hospital recovery care center is coordinated through the hospital social work department, these provisions must be consistent with subsection (x) of this section and must be defined in policies and procedures of the respective hospital social work department and the in-hospital recovery care center.

(x) **Social work. Out of hospital recovery care centers**

(1) Personnel and staffing requirements

(A) The delivery of social work services shall be provided by a social worker who is qualified under subsection (a) (16) of this section.

(B) If the delivery of social work services is provided by a baccalaureate level social worker, the center shall contract for regular consultation by a social work consultant who is qualified under subsection (a) (15) of this section, on no less than a monthly basis, to review the social work service program.

(C) When consultation is required, the consultant shall prepare a written report to the administrator of each visit describing hours visited, policy and procedure review, medical record review, inservice education and other significant activities.

(D) The center shall provide or contract for sufficient hours of social work service to meet the medically related psychosocial needs of all patients but not less than a ratio of one (1) hour per week per licensed bed.

(2) Social work service provision

(A) Written policies and procedures shall be developed by a social worker who is qualified under subsection (a) (16) of this section or a social work consultant who is qualified under subsection (a) (15) of this section and ratified by the governing body, and shall include, but not necessarily be limited to:

(i) identifying the responsibilities and duties of personnel who will be providing social work services to the patients;

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(ii) conducting a social work intake assessment for all patients within seventy-two (72) hours of admission;

(iii) referring a patient or his or her next of kin or legal representative to appropriate agencies for financial assistance, support services, counseling services, legal services, and residential services as needed if such referrals have not already been made;

(iv) serving as liaison between patients, families, facility staff, hospital, institution or community agency staff and caregivers and significant others as necessary; and

(v) ensuring the confidentiality of all patients' social, emotional and medical information.

(B) Social work services shall be provided to assist each patient or his or her next of kin or legal representative in adjusting to the social and emotional aspects of the patient's illness, treatment(s) and stay in the center. Services provided to the patient shall be documented in the patient's medical record.

(C) The social worker or social work consultant shall be responsible for reviewing the discharge or transfer of each patient.

(D) All staff of the center shall receive inservice training by a social worker or social work consultant at least twice a year in an area specific to the needs of the center's patient population.

(y) **Pharmaceutical services. In-hospital recovery care center.** Pharmaceutical services for in-hospital recovery care centers shall ensure the availability of pharmaceutical services to meet the needs of the patients. All such pharmaceutical services shall be provided in accordance with applicable federal and state laws and regulations and hospital policies and procedures.

(z) **Pharmaceutical services. Out-of-hospital recovery care center**

(1) Services

(A) The center shall ensure the availability of pharmaceutical services to meet the needs of the patients. All such pharmaceutical services shall be provided in accordance with all applicable federal and state laws and regulations. Drug distribution and dispensing functions shall be conducted through a pharmacy licensed in Connecticut.

(B) The pharmaceutical services obtained by the center shall be provided under the supervision of a pharmacist.

(i) The center shall have a written agreement with a pharmacist to serve as a consultant on pharmaceutical services.

(ii) The consultant pharmacist shall visit the center at least every three (3) months to review the pharmaceutical services provided, make recommendations for improvements and monitor the service to ensure the ongoing provision of accurate, efficient and appropriate services.

(iii) Signed and dated reports of the pharmacist's quarterly reviews, findings and recommendations shall be forwarded to the center's administrator, medical director, and director of nursing services and be kept on file in the center for no less than three (3) years.

(iv) The center shall ensure that a pharmacist is responsible for the following functions: compounding, packaging, labeling, dispensing and distributing all drugs to be administered

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to patients; monitoring patient drug therapy for potential drug interactions and incompatibilities; notifying attending physicians of any potential drug interactions and incompatibilities which are identified during this review; and inspecting all areas within the center where drugs (including emergency supplies) are stored at least quarterly, to ensure that all drugs are properly labeled, stored and controlled.

(2) Proper space and equipment shall be provided within the center for the storing, safeguarding, preparation, dispensing and administration of drugs.

(A) Any medication storage or administration area shall serve clean functions only and shall be well illuminated and ventilated.

(B) All medication cabinets shall be closed and locked when not in use unless they are stationary cabinets located in a locked room that serves exclusively for storage of drugs and supplies and equipment used in the administration of drugs.

(C) Controlled substances shall be stored and handled in accordance with provisions set forth in Chapter 420b of the Connecticut General Statutes and regulations thereunder.

(3) The center shall develop, implement and enforce written policies and procedures for control and accountability, distribution, and assurance of quality of all drugs and biologicals, which shall include, but not necessarily be limited to, the following:

(A) Records shall be maintained for all transactions involved in the provision of pharmaceutical services as required by law and necessary to maintain control of, and accountability for, all drugs and pharmaceutical supplies.

(B) Drugs shall be distributed in the center in accordance with the following requirements:

(i) All medications shall be dispensed to patients on an individual basis except for predetermined floor stock medication.

(ii) Floor stock shall be limited to emergency drugs, contingency supplies of legend drugs for initiating therapy when the pharmacy is closed, and routinely used non-legend drugs.

(iii) Emergency drugs shall be readily available to staff in a designated location.

(C) Drugs and biologicals shall be stored under proper conditions of security, segregation and environmental control at all storage locations.

(i) Drugs shall be accessible only to legally authorized persons and shall be kept in locked storage at any time a legally authorized person is not in immediate attendance.

(ii) All drugs requiring refrigeration shall be stored separately in a locked refrigerator or in a locked room that is used exclusively for medication and medication adjuncts.

(iii) The inside temperature of a refrigerator in which drugs are stored shall be maintained within a 36° to 46° Fahrenheit range.

(D) All drugs shall be kept in containers that have been labeled by a pharmacist or in their original containers labeled by their manufacturer and shall not be transferred from the containers in which they were obtained except for preparation of a dose for administration.

(E) Drugs and biologicals shall be properly labeled as follows:

(i) Floor stock containers shall be labeled with at least the following information: name

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and strength of drug; manufacturer's lot number or internal control number; and expiration date.

(ii) The label for containers of medication obtained from a community pharmacy shall include at least the following information: name, address and telephone number of the dispensing pharmacy; name of the patient; name of the prescribing practitioner; name, strength and quantity of drug dispensed; date of dispensing the medication; route of administration; and expiration date. Specific directions for use must be included in the labeling of prescriptions containing controlled substances.

(iii) The label for containers of medication dispensed to patients for inpatient self-care use or at discharge from the center shall include at least the following information: name, address and telephone number of the dispensing pharmacy; name of the patient; name of the prescribing practitioner; specific directions for use; name, strength, quantity of the drug dispensed; route of administration; and date of dispensing.

(iv) In cases where a multiple dose package is too small to accommodate a standard prescription label, the standard label may be placed on an outer container into which the multiple dose package is placed. A reference label containing the name of the patient, prescription serial number and the name and strength of the drug shall be attached to the actual multiple dose package. Injectables intended for single dose that are ordered in a multiple quantity may be banded together for dispensing and one label placed on the outside of the banded package.

(F) Drugs on the premises of the center that are outdated, visibly deteriorated, unlabeled, inadequately labeled, discontinued, or obsolete shall be disposed of in accordance with the following requirements:

(i) Controlled substances shall be disposed of in accordance with Section 21a-262-3 of the Regulations of Connecticut State Agencies.

(ii) Non-controlled substances shall be destroyed on the premises by a licensed nurse or pharmacist in the presence of another staff person, in a safe manner so as to render the drugs non-recoverable. The center shall maintain a record of any such destructions including as a minimum the following information: date, strength, form and quantity of drugs destroyed; and the signatures of the persons destroying the drugs and witnessing the destruction.

(iii) Records for the destruction of drugs shall be kept on file for three (3) years.

(G) Current pharmaceutical reference material shall be kept on the premises in order to provide the professional staff with complete information concerning drugs.

(4) The center shall develop and follow written policies and procedures for the safe prescribing and administration of drugs.

(A) Medication orders shall be explicit as to drug, dose, route, frequency, and if pro re nata (p.r.n.), reason for use.

(i) Controlled substances not specifically limited as to time or number of doses shall be stopped within three (3) days.

(ii) A staff member shall notify the practitioner of the impending stop order prior to the time the drug would be automatically stopped.

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(B) Patients shall be permitted to self-administer medications on a specific written order from the physician. Self-administered medications shall be monitored and controlled in accordance with procedures established in the center. A medication administration record must be utilized to document self-administered medications.

(C) Medication errors and apparent adverse drug reactions shall be recorded in the patient's medical record, reported to the attending physician, director of nursing services, and consultant pharmacist, as appropriate, and described in a full incident report in accordance with subsection (h) of this section.

(5) A pharmacy and therapeutics committee shall oversee the pharmaceutical services provided, make recommendations for improvement thereto, and monitor the service to ensure its accuracy and adequacy.

(A) The committee shall be comprised of at least one (1) pharmacist, the center's director of nursing services, the center's administrator, and a physician.

(B) The committee shall meet at least quarterly, and document its activities, findings and recommendations.

(C) Specific functions of the committee shall, include but not necessarily be limited to the following:

(i) developing procedures for the distribution and control of drugs and biologicals in the center in accordance with this subsection;

(ii) reviewing adverse drug reactions that occur in the center and reporting clinically significant incidents to the federal Food and Drug Administration; and

(iii) reviewing medication errors that occur in the center and recommending appropriate action to minimize the recurrence of such incidents.

(aa) **Intravenous therapy program. In-hospital recovery care centers.** Intravenous therapy in in-hospital recovery care centers shall be provided in a manner consistent with hospital policy and procedures.

(bb) **Intravenous therapy program. Out-of-hospital recovery care centers**

(1) Intravenous therapy program prohibited, exceptions. The administration of IV therapy is prohibited except when administered directly by a licensed physician or as provided in subdivision (2) of this subsection.

(2) Approved IV therapy program. IV therapy may be administered in the center provided the center applies for permission from the commissioner, and the commissioner or the commissioner's designee approves the center's application.

(3) The center shall submit to the department a written protocol that shall demonstrate that the program shall be developed and implemented in a manner that ensures safe care for all patients receiving IV therapy and shall include but not necessarily be limited to the following:

(A) the name and credentials of the IV therapy trainer in the event the facility elects to conduct an in-house IV therapy training program;

(B) a description of the objectives, goals and scope of the IV therapy program;

(C) names, titles, duties and responsibilities of persons responsible for the direction,

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supervision and control of the program and alternates to serve in their absences; and

(D) written policies and procedures concerning the establishment of the standards for education, training, ongoing supervision, in-service education and evaluation of all personnel in the program including the IV therapy nurses, licensed nursing personnel and supportive nursing personnel; the origin, form, content, duration and documentation of physician orders for the IV therapy; the safe administration, monitoring, documentation and termination of IV therapy; the safe preparation, labeling and handling of IV admixtures; the procurement, maintenance, and storage of specific types of equipment and solutions that will be used in the program; IV therapy related complications, early recognition of the signs and symptoms of sepsis and acute untoward reaction, and appropriate intervention in a timely manner; surveillance, prevention and review of infections associated with IV therapy; and the ongoing review of the effectiveness and safety of the program to include problem identification, corrective action and documentation of same.

(4) An IV therapy nurse operating an approved IV therapy program pursuant to a physician's order may:

(A) initiate a venipuncture in a peripheral vein and deliver an IV fluid or IV admixture into the blood stream;

(B) deliver an IV fluid or IV admixture into a central vein; and

(C) administer blood and blood components.

(5) An IV therapy nurse may insert and remove Peripheral Intravenous Catheter (PICC) lines upon the order of a physician. There shall be radiological confirmation of catheter position when the tip placement is positioned beyond the axillary vein prior to use of the PICC for any reason.

(6) Only a physician licensed in Connecticut may initiate or terminate a central vein access.

(7) Only an IV therapy nurse or physician may use a central vein access for blood drawing purposes.

(8) A person trained in phlebotomy procedures may use a peripheral line access for blood drawing purposes.

(9) Blood and blood components may be administered provided the following conditions are met:

(A) A physician shall be in the center during the period of time in which the blood and blood components are being administered.

(B) Vital signs (blood pressure, temperature, pulse and respirations) shall be monitored and documented, prior to initiating the infusion of a blood and blood component IV, every fifteen (15) minutes during the first hour of administration and every hour until the transfusion is completed.

(C) The administration of blood or blood components shall be completed in accordance with standards of practice.

(10) An IV therapy nurse may deliver an IV fluid or IV admixture or blood and blood components into the blood stream via existing lines, monitor, care for the venipuncture site,

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terminate the procedure, and record pertinent events and observations.

(11) A log shall be maintained of each IV therapy procedure and blood and blood component administration initiated and shall be made available to the department upon the request of the commissioner. The log shall contain as a minimum the following information: date and time of initiating the procedure, name of patient, name of prescriber, description of the therapy, date and time of terminating the therapy, outcome of the therapy, and complications encountered, if any.

(12) Negative reactions to blood and blood components shall be reported to the department within twenty-four (24) hours and as required by the blood bank of the cooperating hospital.

(13) There shall be no changes in the protocol developed pursuant to subdivision (3) of this subsection or modifications in the scope of the IV therapy program as defined in subsection (a) (11) of this section without the written approval of the commissioner.

(14) Approval to participate in the program may be revoked at any time for failure to comply with this subsection.

(cc) Diagnostic services

(1) All diagnostic services shall be provided only on the order of a Connecticut licensed physician, dentist, podiatrist, physician assistant or advanced practice registered nurse.

(2) Out-of hospital recovery care centers shall arrange for diagnostic services through written agreements with facilities appropriately licensed and certified to provide such services.

(dd) Out-of-hospital recovery care center transfer agreements

(1) A licensed recovery care center shall have a written transfer agreement with one (1) or more hospitals. This agreement shall ensure that:

(A) patients shall be transferred from the center to the hospital and ensured of timely admission to the hospital when transfer is medically appropriate as determined by a physician; and

(B) medical and other information needed for care and treatment of a patient is transferred with the patient.

(2) A licensed recovery care center shall have a written agreement with one (1) or more ambulance service(s) staffed with emergency medical technicians qualified under subsection 19a-179-16 (b) of the regulations of Connecticut State Agencies. This agreement shall ensure an immediate response by the ambulance service for emergency medical services or transportation to a hospital.

(ee) Medical records

(1) The center shall maintain a complete medical record for each patient. All parts of the record pertinent to the daily care and treatment of the patient shall be maintained on the nursing unit in which the patient is located.

(2) The complete medical record that is initiated at the time of admission shall include, but not necessarily be limited to:

(A) patient identification data, including name, date of admission, most recent address

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prior to admission, date of birth, sex, marital status and religion;

- (B) referral source;
- (C) insurance numbers;
- (D) next of kin or legal representative and address and telephone number;
- (E) name of patient's attending physician;
- (F) complete medical diagnosis;
- (G) all initial and subsequent orders by the physician;
- (H) a patient assessment completed upon admission;
- (I) the initial patient care plan which is based on the patient assessment, developed within three (3) hours of the patient's admission, including input by all disciplines involved in the care of the patient within twenty-four (24) hours of admission, containing the identification of patient problems and needs, treatments, approaches and measurable goals and updated as necessary but no less frequently than every seven (7) days;
- (J) a record of all visits by the physician including physician progress notes;
- (K) nurses notes including condition on admission, current condition, ongoing monitoring, changes in patient condition, treatments and responses to such treatments;
- (L) a record of medications administered including the name and strength of drug, date, route and time of administration, dosage administered and with respect to p.r.n. medications, reasons for administration, patient response and result(s) observed;
- (M) documentation of all care and ancillary services rendered;
- (N) summaries of conferences and records of consultations if applicable; and
- (O) record of any physician visits, treatment, medication or service refused by the patient and the patient's understanding of the potential effects of the refusal which shall be documented in the medical record by the physician, physician assistant or registered nurse and signed by the patient whenever possible.

(3) All entries in the patient's medical record shall be typewritten or written in black ink and legible. All entries shall be verified according to accepted professional standards (i.e., legal signature: first name or initial, last name and discipline).

(4) Medical records shall be safeguarded against loss, destruction or unauthorized use.

(5) All medical records, originals or copies, shall be preserved for at least ten (10) years following the death or discharge of the patient. In-hospital recovery care centers shall maintain records according to section 19-13-D3(d) of the regulations of Connecticut State Agencies.

(ff) Discharge planning

(1) Patient education shall begin on the day of admission and shall focus on the individual's immediate post discharge needs.

(2) Every patient shall have a written discharge plan that shall be given to the patient or his or her next of kin or legal representative prior to discharge.

(3) The discharge plan shall include but not necessarily be limited to identification of the patient's needs for continued skilled care or support services and the specific resources to be utilized to meet these needs.

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(4) The discharge plan shall be completed on a timely basis so that appropriate arrangements for post discharge care management are made before discharge.

(5) The discharge plan shall be developed in collaboration with the patient, or his or her next of kin or legal representative, and the social worker and other care providers.

(6) The discharge plan shall be approved by the physician of record.

(7) The written discharge plan shall be signed by the patient or his or her next of kin or legal representative indicating their understanding of the discharge plan of care.

(8) The documentation of the written discharge plan shall be retained as a permanent part of the patient's medical record.

(9) Information necessary to ensure the continuity of care shall be sent to participating providers in a timely manner to ensure continuity of care.

(gg) **Infection control. In-hospital recovery care centers.** Infection control practices for in-hospital recovery care centers shall be consistent with hospital policy, procedure and standards.

(hh) **Infection control. Out-of-hospital recovery care centers**

(1) The center shall develop an infection prevention, surveillance and control program which shall have as its purpose the protection of patients and personnel from nosocomial infections and community-associated infections.

(2) The structure and function of this program shall be approved by, and become a part of the bylaws or rules and regulations of, the medical staff of the center. The authority for this program shall be delegated to an infection control committee which shall report on its activities with recommendations on at least a quarterly basis to the medical advisory board for their consideration and action.

(3) The membership of the infection control committee shall include representatives from the center's administration, medical staff, nursing staff, pharmacy, dietary, maintenance and housekeeping. The committee shall meet at least quarterly. Minutes of all meetings shall be maintained for ten (10) years.

(4) The infection control committee shall:

(A) adopt working definitions of nosocomial infections;

(B) develop standards for surveillance of incidence of nosocomial infections and conditions predisposing to infection;

(C) develop a mechanism for monitoring and reporting infections in patients and environmental conditions with infection potential; and

(D) develop control measures including an isolation policy, aseptic techniques, and a personal health program.

(5) The chairman of the infection control committee shall be a Connecticut licensed physician and shall be a member of the active medical staff of a general hospital licensed in Connecticut.

(6) The services of a physician, board certified in infectious diseases, shall be available to the infection control committee and chairman, as needed.

(7) There shall be a registered nurse employed by the center who shall conduct the

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infection control program as directed by the infection control committee. This individual shall be directly responsible to, and be a member of, the infection control committee. This individual shall make a monthly report to the medical director and a quarterly report to the medical advisory board.

(8) The infection control committee shall meet at least quarterly and shall, at a minimum:

(A) review information obtained from day-to-day surveillance activities of the program;

(B) review and revise existing standards; and

(C) report to the active organized medical staff.

(9) There shall be quarterly in-service education programs regarding infection prevention, surveillance and control for appropriate personnel. Documentation of these programs shall be available to the department for review.

(10) The minutes of the committee meetings shall document the review and evaluation of the surveillance data and the development and revision of measures for control of infection. These records shall be available to the department for review.

(11) The center shall comply with the requirements for the handling and disposing of biomedical wastes in accordance with applicable state and federal laws and regulations.

(ii) **Quality assurance. In-hospital recovery care centers.** In-hospital recovery care center quality assurance programs shall be consistent with the hospital program, procedures and standards to include all quality assurance components identified under subsection (jj) of this section.

(jj) **Quality assurance. Out-of-hospital recovery care centers.** The center shall have a quality assurance program to monitor and evaluate the quality and appropriateness of patient care, measure patient outcomes and pursue ways to improve patient care and resolve problems.

(1) The quality assurance program shall be implemented by a quality assurance committee comprised of the administrator, medical director, director of nursing services, at least one (1) physician from a participating surgical specialty and one (1) from medicine, two (2) staff registered nurses, one (1) of whom shall be the infection control nurse, and the social worker.

(2) The quality assurance committee shall adopt written procedures for fulfilling their responsibilities. These procedures are subject to approval by the governing body and the department.

(3) The quality assurance committee shall:

(A) review the appropriateness of patient admissions to the center;

(B) review appropriateness of the professional services provided in the center;

(C) identify opportunities for improving patient care and services;

(D) review pharmaceutical services and the appropriateness of medication usage for patients in conjunction with the consultant pharmacist;

(E) review the records of all patients requiring a third day of care for continued appropriateness of setting;

(F) review within twenty-four (24) hours all patient cases where a medical emergency

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or death occurs and submit to the department, within seven (7) days, a written report of their findings in such cases;

(G) review for appropriateness of admission and services, all patient cases requiring unexpected transfer to an acute facility and report to the medical director within twenty-four (24) hours of the transfer;

(H) provide for quarterly review of availability of resources necessary to respond to medical emergencies;

(I) review the procedures and surveillance program for minimizing the sources and transmission of infection, including post discharge;

(J) evaluate all services provided by contract or agreement on an annual basis or more frequently as necessary;

(K) provide for medical records review to determine accuracy and completeness of information contained in the patients' medical records; and (L) review the records of all patients who are readmitted to the recovery care center or acute care facility within ten (10) days after discharge for appropriateness of services and discharge and report such findings to the department on a quarterly basis.

(4) The quality assurance committee shall meet at least quarterly and report its findings and activities to the center's governing body and medical staff.

(5) The quality assurance committee shall be responsible to ensure that appropriate follow-up results.

(6) Minutes shall be taken at each meeting, retained at the center for five (5) years and made available to the department upon its request.

(kk) Physical environment standards

(1) General provisions

(A) Review of drawings and specifications

(i) No new construction of or alteration to a recovery care center, new or existing, shall be undertaken until final project drawings and specifications have been approved by the department.

(ii) Concurrent with the submission of drawings and specifications, a project narrative shall be submitted to the department which includes a description of the overall physical project. If it is to be a distinct center within an existing licensed facility, a description of the project with the proposed use of existing services to be utilized shall also be included.

(iii) Each center shall demonstrate compliance with building and fire safety codes prior to project approval by the department.

(iv) The department may require submission of site, architectural, structural, heating, ventilation, plumbing and electrical drawings of the existing structure for alteration projects.

(v) In addition to a narrative description of the physical project, the sponsor for each project shall provide a functional program narrative for the recovery care center which defines services and programs to be provided.

(B) Recovery care center occupancy shall be classified as a health care occupancy. The recovery care center shall comply with the provisions of the State Building Code as a

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rehabilitative health care facility. The standards established for the construction, renovation, alteration, maintenance and licensure of all facilities as adopted by the Commissioner of the Department of Public Safety, are hereby incorporated and made a part hereof and include but are not necessarily limited to:

- (i) State of Connecticut Building Codes;
- (ii) State of Connecticut Fire Safety Code; and
- (iii) National Electrical Code.

(C) The standards established within the Public Health Code of the State of Connecticut for the construction, renovation, alteration, maintenance and licensure of all facilities, as may be amended from time to time, are hereby incorporated and made a part hereof by reference.

(2) Waiver(s)

(A) The commissioner or his or her designee, in accordance with the general purposes and intent of this section, may waive provisions of this subsection if the commissioner determines that such waiver would not endanger the life, safety or health of any patient. The commissioner shall have the power to impose conditions which assure the health, safety and welfare of patients upon the grant of such waiver, or to revoke such waiver upon a finding that the health, safety, or welfare of any patient has been jeopardized.

(B) Any facility requesting a waiver shall apply in writing to the department. Such application shall include:

- (i) the specific regulations for which the waiver is requested;
- (ii) reasons for requesting the waiver, including a statement of the type and degree of hardship that would result to the facility upon enforcement of the regulations;
- (iii) the specific relief requested; and
- (iv) any documentation which supports the application for waiver.

(C) In consideration of any application for waiver, the commissioner or his or her designee may consider the level of care provided, the maximum patient capacity, the impact of a waiver on care provided, and alternative policies or procedures proposed.

(D) The department reserves the right to request additional information before processing an application for waiver.

(E) Any hearing held in conjunction with an application for waiver shall be held in conformance with Chapter 54 of the Connecticut General Statutes and sections 19a-4-1 through 19a-4-31 of the regulations of Connecticut State Agencies, as applicable.

(3) General conditions

(A) Applicability. This subdivision covers freestanding facilities or a distinct part of a health care facility and represents minimum requirements for new construction or alterations.

(B) Ancillary services. When the recovery care center is part of, or contractually linked with another facility, services such as dietary, storage, pharmacy, and laundry may be shared insofar as practical. In some cases, ancillary service requirements may be met by the principal facility. In other cases, programmatic concerns and requirements may dictate

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separate services.

(C) Basic requirements

(i) The recovery care center shall provide sufficient space to accommodate all administrative, business, clinical, medical records, professional staff and support functions.

(ii) The sponsor shall demonstrate that the project drawings will meet the functional program submitted to the department.

(iii) A separate entry to the recovery care center shall be provided.

(iv) Services of the recovery care center shall be provided in a distinct location of the facility.

(v) Site locations shall be accessible to emergency service vehicles.

(vi) Paved walkways shall be provided for each exit from the building leading to a driveway or street.

(vii) Handicapped and staff visitor parking shall be provided in proximity to the recovery care center entrance.

(D) Administration and public areas. The following shall be provided:

(i) an entrance at grade level, sheltered from inclement weather, and accessible to the handicapped;

(ii) a lobby to include a reception and information counter or desk, waiting space(s), access to public toilet facilities, public telephones, and drinking fountain(s);

(iii) spaces for private interviews relating to social service, credit or admissions;

(iv) general or individual office(s) for business transactions, medical and financial records and administrative and professional staffs;

(v) multipurpose room(s) for conferences, meetings and education purposes;

(vi) storage for office equipment and supplies; and

(vii) adequate space for reviewing, dictating, sorting, recording, and storing of medical records.

(E) Nursing unit. Each nursing unit shall comply with the following:

(i) The size of the nursing unit shall not exceed forty-five (45) beds.

(ii) The maximum travel distance from the nurses' station to a patient bedroom door shall be one hundred and fifty (150) feet.

(F) Patient rooms

(i) Maximum room occupancy shall be two (2) patients.

(ii) Minimum room areas (exclusive of toilets, closets, wardrobes, alcoves or vestibules) shall be one hundred and twenty (120) square feet for a single bedroom and one hundred (100) square feet per bed in multiple-bed rooms.

(iii) In multiple-bed rooms, clearance shall allow for the movement of beds and equipment.

(iv) The dimensions and arrangement of rooms shall be such that there is a minimum of four (4) feet clearance between the sides and foot of the bed and any wall, other fixed obstruction, or furniture and six (6) feet between beds in multiple-bed rooms.

(v) Handwashing facilities shall be provided within each patient room.

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

(vii) The toilet room shall contain a water closet and a handwashing fixture and the door should swing outward or be double acting.

(viii) A toilet room may not serve more than two (2) patients.

(ix) All associated patient bathrooms and toilet rooms shall be accessible to the physically disabled.

(x) In recovery care centers which specialize in rehabilitative services, a minimum of fifty percent (50%) of patient rooms shall be equipped with a private bathing unit.

(xi) Cubicle curtains shall be provided in each bedroom.

(xii) The design for privacy shall not restrict patient access to the entrance, lavatory or toilet.

(xiii) The following equipment shall be provided for each patient in each bedroom: one (1) closet or wardrobe with adjustable clothes rod and a shelf of sufficient size and design to hang clothing; one (1) dresser with three (3) separate storage areas for patient clothing; one (1) adjustable hospital bed with gatch spring, and side rails; one (1) moisture proof mattress; one (1) enclosed bedside table; one (1) overbed table; one (1) chair; one (1) full length mirror; and one (1) piped oxygen and vacuum outlet.

(G) Isolation Room(s)

(i) At least one (1) isolation room, designed to minimize infection hazards to or from the patient, shall be provided for each nursing unit.

(ii) Each isolation room shall contain only one (1) bed and shall be located within individual nursing units. These rooms may be used for regular care when not required for isolation cases.

(iii) A handwash sink shall be provided within the room.

(iv) Room entry shall be through a work area that provides for facilities that are separate from patient areas for handwashing, gowning, and storage of clean and soiled materials. The work area entry shall be a separate enclosed anteroom. A viewing panel shall be provided for observation of each patient by staff from the anteroom.

(v) One (1) separate anteroom may serve several isolation rooms.

(vi) Toilet, shower or bathing unit, and handwashing facilities are required for each isolation room. These shall be arranged to permit access from the bed area without the need to enter or pass through the work area of the vestibule or anteroom.

(vi) Piped oxygen and vacuum shall be provided.

(H) Central Bathing Facilities. At least one (1) central bathing unit shall be provided in each nursing unit.

(i) One (1) shower or bathing unit shall be provided for each ten (10) beds not equipped with a private bathing unit.

(ii) Each bathtub or shower shall be in an individual room or enclosure that provides privacy for bathing, drying, and dressing.

(iii) Special bathing facilities, including space for attendant, shall be provided for patients

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on stretchers, carts, and wheelchairs.

(iv) At least one (1) bathing unit shall have four (4) feet clearance of three (3) sides.

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

(vi) Controls shall be located outside shower stalls.

(vii) Patient toilet rooms shall be conveniently located to each central bathing facility.

(viii) A handwash sink and storage cabinet(s) shall be provided within the central bathing facility.

(ix) Patient toilet room(s) of handicapped design shall be conveniently located to multi-purpose rooms and may also be designated for public use.

(x) At least one (1) handicapped accessible shower shall be located within each central bathing unit.

(I) Nursing Station

(i) The area shall have space for counters and storage, and shall have convenient access to handwashing facilities. The station shall permit visual observation of traffic into the unit. A minimum of one hundred and fifty (150) square feet for a thirty (30) bed nursing unit or two hundred (200) square feet for a forty-five (45) bed nursing unit shall be provided.

(ii) A dictation area shall be adjacent to, but separate from the nurse's station.

(iii) A separate charting room of one hundred (100) square feet shall be located adjacent to the nursing station.

(iv) A storage area for active charts and office supplies shall be provided.

(v) Nurse or supervisor office space shall be provided.

(vi) A staff toilet room shall be conveniently located to each nursing station.

(vii) Staff lounge and locker facilities shall be provided. These facilities may be on another floor.

(viii) Lockable closets, drawers, or compartments shall be provided for safekeeping of staff personal effects.

(ix) Emergency equipment storage space that is easily accessible to staff, such as a crash cart, shall be available.

(x) Essential equipment. The following medical equipment shall be provided at each nursing station: one (1) gurney stretcher and one (1) wheelchair; one (1) suction machine; one (1) oxygen cylinder with transport carrier; manual breathing bag, mask and airways; cardiac defibrillator; cardiac monitoring equipment; tracheotomy set; emergency medical equipment and related supplies specified by the medical staff; and cardiac board. The following support equipment shall be provided at each nursing station: one (1) mobile chair scale; one (1) water cooler; public telephone; and one (1) ice machine.

(J) Examination and treatment room. One (1) examination and treatment room shall be provided for each nursing unit. Such rooms shall have a minimum floor area of one hundred and twenty (120) square feet. The room shall contain a handwashing fixture, storage facilities, a desk, counter, or shelf space for writing and one (1) oxygen and vacuum outlet.

(K) Clean utility room. There shall be a clean utility room of a least one hundred (100)

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square feet. It shall minimally contain a counter, enclosed locked storage cabinets and handwashing facilities.

(L) Soiled utility room. There shall be a soiled utility room of at least one hundred and ten (110) square feet. It shall minimally contain a handwashing facility, a bedpan flushing and washing device, a flushrim sink, locked cabinet storage and a work counter. The room may be utilized for the temporary storage of bio-medical waste.

(M) Medication preparation room. There shall be a medication preparation room of at least eighty (80) square feet. The room shall be visually controlled from the nurse's station. It shall contain a work counter, sink, refrigerator, locked storage for controlled drugs and space for medication carts.

(N) Soiled linen holding room. A separate room of at least sixty (60) square feet shall be provided.

(O) Clean linen storage. A separate closet shall be designated for the storage of linen, blankets, pillows, towels and personal belongings.

(P) Bulk equipment storage room. There shall be a bulk equipment storage room of at least one hundred and fifty (150) square feet for thirty (30) beds or two hundred (200) square feet for forty-five (45) beds.

(Q) Wheelchair storage. Storage space for wheelchairs shall be available.

(R) Nourishment station. This room shall contain a work counter, refrigerator, storage cabinets and a sink for serving nourishments between meals. Ice for resident consumption shall be provided by ice maker units.

(S) Medical supply room. There shall be a medical supply room of at least one hundred and fifty (150) square feet.

(T) Oxygen storage. Storage space of twenty-five (25) square feet for oxygen shall be provided.

(U) Patient support areas. Each recovery care center shall provide the following:

(i) a dining area with a minimum of twenty (20) square feet per patient in a distinct, centrally located area;

(ii) a lounge with a minimum area of two hundred and fifty (250) square feet for each thirty (30) beds or fraction thereof, with at least one (1) lounge on each nursing unit; and

(iii) storage space for supplies and resident personal needs.

(V) Rehabilitative therapy areas. Recovery care centers which specialize in rehabilitative services shall provide areas and equipment necessary for the effective function of the program. Each rehabilitative therapy area shall include the following:

(i) office and clerical space;

(ii) reception and control station(s) with visual control of waiting and activities areas which may be combined with office and clerical space;

(iii) patient waiting area(s) with provisions for wheelchairs;

(iv) space for storing wheelchairs and stretchers out of traffic; and

(v) a janitor's closet with a service sink.

(W) Physical therapy. If physical therapy is a service provided, the following minimum

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facilities shall be included:

- (i) individual treatment area(s) with cubicle curtains for visual privacy;
- (ii) handwashing facilities for staff conveniently located at each treatment space (one (1) handwashing facility may serve several treatment stations);
- (iii) exercise area and related equipment;
- (iv) clean linen and towel storage;
- (v) separate storage for soiled linens, towels and supplies;
- (vi) patient dressing areas and lockers;
- (vii) a shower for patient use;
- (viii) provisions for thermotherapy, diathermy, and ultrasonics when required by the functional narrative program;
- (ix) toilet facilities located within the room that are accessible to the handicapped, which may also be used for toilet training; and
- (x) a water cooler.

(X) Occupational therapy. If this service is provided, the following shall be included at a minimum:

- (i) work areas and counters suitable for wheelchair access;
- (ii) handwashing facilities;
- (iii) storage for supplies and equipment; and
- (iv) therapeutic equipment for activities of daily living.

(Y) Hydro therapy. If this service is provided, the following shall be included at a minimum:

- (i) patient dressing areas and lockers;
- (ii) showers for patient use;
- (iv) limb and body tanks required to meet recovery care center narrative program requirements;
- (v) individual treatment areas with cubicle curtains for visual privacy;
- (vi) handwashing facilities; and
- (vii) handicapped toilet facilities which may be shared if appropriate other facilities are in proximity.

(Z) Speech and hearing therapy. If this service is provided the following elements shall be included at a minimum:

- (i) office space for evaluation and treatment; and
- (ii) space for equipment and storage.

(AA) Respiratory therapy. If respiratory service is provided, the following elements shall be included at a minimum:

- (i) office and clerical space with provision for filing and retrieval of patient records;
- (ii) room(s) for patient education and demonstration;
- (iii) storage space for equipment and supplies;
- (iv) physical separation of the space for receiving and cleaning soiled materials from the space for storing of clean equipment and supplies; and

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(v) handwashing facilities.

(BB) Laboratory services. If laboratory procedures are performed on-site, provisions shall be made for space and equipment and Federal Clinical Laboratory Improvement Act (CLIA) standards shall be met.

(CC) Dietary Facilities

(i) The functional elements of the dietary department shall provide for services that are separate from other service areas and sized to permit working space and equipment, for receiving, storing, food preparation, tray assembly, serving of food and disposal of waste products and returnable items.

(ii) The following minimum facilities shall be provided within the dietary department: receiving, breakdown and control areas; storage spaces for bulk, refrigerated and frozen foods; stock of a minimum of three (3) days supplies; freezers, capable of maintaining temperatures down to freezing; food preparation work spaces and equipment; tray assembly area; food cart distribution system with space for storage, loading, distribution, receiving and sanitizing; a dishwashing room which shall be designed to separate dirty and clean dishes and include a breakdown area and food cart hold area; waste storage room; potwashing facilities which include a three (3) pot sink; handwashing facilities located conveniently in the area; janitorial and housekeeping services; office space for food service supervisor and dietitian; toilet and locker spaces; and ice making equipment.

(iii) The dietary service shall provide for the protection of food delivered to ensure freshness, retention of hot or cold temperature and avoidance of contamination.

(iv) Under counter conduits, piping and drains shall not interfere with cleaning of the floor below the equipment. No plumbing lines shall be exposed overhead.

(v) All cooking equipment shall be equipped with automatic shut-off devices to prevent excessive heat buildup.

(vi) Dining space shall be provided for staff.

(DD) Laundry services

(i) Each recovery care center shall have provisions for storing and processing clean and soiled linen for appropriate patient care and infection control. Processing may be done within the center, in a separate building on or off-site, or in a commercial or shared laundry.

(ii) The following elements shall be included: a separate room for receiving and holding soiled linen until ready for pickup or processing, a clean linen storage room, and cart storage area.

(iii) Employee handwashing facilities shall be provided in each area where clean and soiled linen is processed or handled.

(iv) If linen is processed in a laundry on-site, the recovery care center shall provide a laundry processing room with commercial-type equipment that is arranged to permit an orderly work flow and minimize cross traffic that might mix soiled and clean operations.

(v) Linens and towels shall be provided, sufficient for four (4) times the licensed capacity of the center.

(EE) Waste storage and disposal. Waste processing services shall provide for the sanitary

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storage, treatment or disposal of waste and infectious materials of the center.

(FF) Housekeeping Rooms. Housekeeping rooms shall be provided throughout the facility as required to maintain a clean and sanitary environment. Each housekeeping room shall contain a floor receptor or service sink and storage space for housekeeping equipment and supplies. There shall not be less than one (1) housekeeping room for each floor or nursing unit.

(GG) Elevators

(i) Where patient beds or patient facilities and services are located on any floor other than the grade level entrance, the size and number of elevators shall be based on the following criteria: number of floors, number of beds per floor, procedures or functions performed on upper floors, and level of care provided.

(ii) In no instance shall elevators be less than the following: for one (1) to sixty (60) beds located above the main floor, one (1) hospital elevator; or for sixty-one (61) to two hundred (200) beds located above the main floor, two (2) hospital elevators.

(iii) An elevator shall be provided to service facilities located above or below the first floor such as materials handling and infectious waste.

(iv) At least one (1) elevator shall be connected to the emergency electrical equipment system.

(HH) Service and equipment areas. The following shall be provided as essential for effective service and maintenance functions:

- (i) rooms for boilers, mechanical and electrical equipment;
- (ii) general maintenance shop(s) for repair and maintenance;
- (iii) general storage room(s); and
- (iv) storage for solvents and liquids.

(II) Operational features

(i) Patient rooms shall open into a common corridor.

(ii) Doors. The minimum width of a door to patient bedrooms, central bathing units, examination and treatment rooms and to treatment and rehabilitation areas shall not be less than forty-six (46) inches. All other doors to patient and staff use areas shall not be less than three (3) feet wide. Floor hardware for patient use shall be of a design to permit ease of opening. Doors to all rooms containing bathtubs, showers, and water closets for patient use shall be equipped with privacy hardware that permits emergency access without keys. When such rooms have only one (1) entrance, the door shall open outward or be double acting.

(iii) Corridors shall be a minimum width of eight (8) feet in patient use areas. No objects shall be located so as to project into the required width of corridors.

(iv) Handrails shall be located on both sides of patient use corridors and mounted thirty-two (32) to thirty-four (34) inches above the floor. Rail ends shall be finished to minimize the potential for personal injury.

(v) Grab bars with sufficient strength and anchorage to sustain two hundred and fifty (250) pounds for five (5) minutes shall be provided at all patient toilets, showers and tubs.

(vi) Windows. Patient rooms shall be on an outside wall and have operable windows

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that open from the inside. Windows shall have a protective device so as to prevent accidental falls when open. Windows in patient bedrooms shall not be higher than thirty-six (36) inches above the finished floor to the sill. Windows and outer doors that may be left open shall have insect screening.

(vii) Thresholds shall be designed to comply with accessibility standards in accordance with the Americans with Disabilities Act.

(viii) Full size mirrors shall be arranged to accommodate their convenient use by patients in wheelchairs and ambulatory patients in patient bedrooms.

(ix) Patient bedrooms shall be numbered and the room capacity posted on the corridor wall on the door knob side and correlated with the fire evacuation plan.

(x) Soap and paper towel dispensers shall be provided at each staff use sink.

(xi) Ceilings shall be a minimum of eight (8) feet high in corridors, patient rooms and ancillary service areas.

(xii) Fire extinguishers shall be provided in recessed locations throughout the building as established by the local fire marshal.

(JJ) Finishes

(i) Cubicle curtains and draperies shall be non-combustible or flame-retardant as prescribed in both the large and small scale tests in National Fire Protection Association (NFPA) standard 701.

(ii) Materials provided by the facility for finishes and furnishings, including mattresses and upholstery, shall comply with NFPA 101.

(iii) Floor materials shall be readily cleanable, appropriate for the location and be maintained for patient safety. Floors in areas used for food preparation and assembly shall be water-resistant. Floor surfaces, including tile joints, shall be resistant to food acids. Floor materials shall not be adversely physically affected by germicidal cleaning solutions. Floors subject to traffic while wet (such as shower and bath areas, kitchens, and similar work areas) shall have a slip-resistant surface.

(iv) Wall bases in areas subject to routine wet cleaning shall be covered, integrated with the floor, and tightly sealed.

(v) Wall finishes shall be washable, smooth and moisture-resistant.

(vi) Floor and wall openings for pipes, ducts, and conduits shall be tightly sealed to resist fire and smoke and to minimize entry of pests.

(vii) The finishes of all exposed ceilings and ceiling structures in resident rooms and staff work areas shall be readily cleanable.

(KK) Medical gas and vacuum systems

(i) The installation of nonflammable medical gas and air systems shall comply with the requirements of the most current NFPA 99 Health Care Facilities. When any piping or supply of medical gases is installed, altered, or augmented, the altered zone shall be tested and certified as required by NFPA 99.

(ii) Clinical vacuum system installations shall be in accordance with the most current NFPA 99.

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(iii) All piping, except control-line tubing, shall be identified. All valves shall be tagged, and a valve schedule shall be provided to the facility owner for permanent record and reference.

(LL) Mechanical standards

(i) Boilers shall have the capacity, based upon the net ratings published by the Hydronics Institute or another acceptable national standard that is widely accepted in the boiler industry, to supply the normal heating and hot water to all systems and equipment. Their number and arrangement shall accommodate facility needs despite the breakdown or routine maintenance of any one boiler. The capacity of the remaining boiler(s) shall be sufficient to provide hot water service for clinical, dietary, and patient use.

(ii) Patient occupied areas shall be maintained in a temperature range of 72° and 75° Fahrenheit for heating purposes. Non-patient use areas may be maintained in a temperature range of 70° and 75° Fahrenheit.

(iii) Air conditioning shall be provided in all patient use areas and maintained in a range of 70° and 76° Fahrenheit during the cooling season.

(iv) The ventilation systems shall be designed and balanced to provide directional flow as in Table 1.

Table 1 PRESSURE RELATIONSHIPS AND VENTILATION OF CERTAIN AREAS¹

<i>Area designa- tion</i>	<i>Air move- ment relation- ship to adjacent area</i>	<i>Minimum air changes of outdoor air per hour</i>	<i>Minimum total air change per hour</i>	<i>All air exhausted directly to outdoors</i>	<i>Recircu- lated by means of room units</i>	<i>Relative humidity (%)</i>
PATIENT CARE						
Patient room	—	2	2	—	—	50-60
Patient area corridor	—	—	2	—	—	45-60
Toilet room	In	—	10	Yes	—	—
Isolation Room	In	1	6	Yes	No	—
Isolation An- teroom	In	—	10	Yes	No	—
DIAGNOSTIC AND TREATMENT						
Examina- tion/Treat- ment	—	2	6	—	—	—

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<i>Area designa- tion</i>	<i>Air move- ment relation- ship to adjacent area</i>	<i>Minimum air changes of outdoor air per hour</i>	<i>Minimum total air change per hour</i>	<i>All air exhausted directly to outdoors</i>	<i>Recircu- lated by means of room units</i>	<i>Relative humidity (%)</i>
Physical ther- apy	In	2	6	—	—	—
Hydro ther- apy	In	2	6	—	—	—
Occupational therapy	In	2	6	—	—	—
Speech and Hearing	In	2	6	—	—	—
Soiled work- room	In	2	10	Yes	No	—
Clean work- room	Out	2	4	—	—	—
Medication Room	—	—	4	—	—	—
SUPPORT						
Laundry, gen- eral	—	2	10	Yes	No	—
Soiled linen	In	—	10	Yes	No	—
Clean linen storage	Out	—	2	Yes	No	—
Laboratory	In	—	6	Yes	No	—
SERVICE						
Food prepara- tion center	—	2	10	Yes	Yes	—
Warewashing room	In	—	10	Yes	Yes	—
Dietary day storage	—	—	2	Yes	No	—
Janitor closet	In	—	10	Yes	No	—
Bathroom	In	—	10	Yes	No	—

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<i>Area designation</i>	<i>Air movement relationship to adjacent area</i>	<i>Minimum air changes of outdoor air per hour</i>	<i>Minimum total air change per hour</i>	<i>All air exhausted directly to outdoors</i>	<i>Recirculated by means of room units</i>	<i>Relative humidity (%)</i>
Waste Storage	In	—	10	Yes	No	—

¹

1 1 The ventilation rates in this table cover ventilation for comfort, as well as for asepsis and odor control in areas of recovery care centers that directly affect patient care and are determined based on health care facilities being predominantly no smoking facilities. Where smoking may be allowed, ventilation rates shall need adjustments.

(v) Design of the ventilation system shall, insofar as possible, provide that air movement is from clean to less clean areas.

(vi) All air-supply and air-exhaust systems for interior rooms shall be mechanically operated.

(vii) Corridors shall not be used to supply air to or exhaust air from any room.

(viii) All systems which serve more than one smoke or fire zone shall be equipped with smoke detectors to shut down fans automatically. Access for maintenance of detectors shall be provided at all dampers.

(MM) Plumbing and other piping systems

(i) Plumbing fixtures. All fixtures used by medical staff, nursing staff and food handlers shall be trimmed with valves which can be operated without the use of hands. Where blade handles are used for this purpose, they shall be at least four and one-half (4 ½) inches in length, except that handles on clinical sinks shall be not less than six (6) inches long. Single lever faucet handles shall extend six (6) inches in length.

(ii) Water supply systems. Systems shall be designed to supply water to the fixtures and equipment on the upper floor at a minimum pressure of fifteen (15) pounds per square inch during maximum demand periods. Each water service main, branch main, riser and branch to a group of fixtures shall be valved. Stop valves shall be provided at each fixture. Hot water plumbing fixtures intended for patient use shall carry water at temperatures between 105° and 120° Fahrenheit.

(iii) Vacuum breakers shall be installed on hose bibbs and supply nozzles used for connection of hoses in housekeeping sinks, bedpan-flushing attachments, and outdoor hose bibbs.

(NN) Electrical standards

(i) Circuit breakers or fusible switches shall be enclosed with a dead-front type of assembly. The main switchboard shall be located in a separate enclosure accessible only to authorized persons.

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(ii) Lighting and appliance panel boards shall be provided for the circuits on each floor. This requirement does not apply to emergency system circuits.

(iii) All spaces within the building, approaches thereto, and parking lots shall have electric lighting.

(iv) Patient bedrooms shall have general room lighting, overbed examination lighting, and a patient accessible reading light. General room lighting shall be switched at the room entrance and be connected to emergency power.

(v) Night lighting shall be provided in the patient bedroom and the toilet room. Night lights shall be switched at the nursing station to assure effective use.

(vi) Receptacles (convenient outlets). Each patient bed shall have a double duplex, hospital grade, grounded receptacle on each side of each bed. In addition, one (1) duplex shall be provided on each other wall in the room. If electric beds are used an additional receptacle shall be provided. At least two (2) receptacles installed at the head of each patient bed shall provide emergency power. Receptacles that provide emergency power shall be color coded red to indicate their use. Duplex grounding receptacles for general use in corridors shall be installed approximately fifty (50) feet apart and within twenty-five (25) feet of ends of corridors; and ground fault circuit interrupters shall be installed at all wet locations.

(OO) Nurse's call system

(i) In patient areas, each patient room shall be served by at least one (1) calling station for two-way voice communication. Each bed shall be provided with a call device. Two (2) call devices serving adjacent beds may be served by one (1) calling station. Calls shall activate a visible signal in the corridor at the patient's door, in the clean workroom, in the soiled workroom, and at the nursing station of the nursing unit. In multi-corridor nursing units, additional visible signals shall be installed at corridor intersections. In rooms containing two (2) or more calling stations, indicating lights shall be provided at each station. Nurse's calling systems at each calling station shall be equipped with an indicating light which remains lighted as long as the voice circuit is operating.

(ii) A nurse's emergency call system shall be provided at each inpatient toilet, bath or shower room.

(iii) A staff emergency assistance system for staff to summon additional assistance shall be provided in examination and treatment rooms, dining, activity, and therapy areas. This system shall annunciate at the nurse station with back-up to another staffed area from which assistance can be summoned.

(PP) Emergency service

(i) The facility shall provide an emergency source of electricity, which shall have the capacity to deliver eighty percent (80%) of normal power and lighting and shall be sufficient to provide for regular nursing care and treatment and the safety of the occupants. Such source shall be reserved exclusively for emergency use.

(ii) As a minimum, each patient bed shall provide one (1) duplex electrical receptacle that is connected to the emergency power source. Task lighting and emergency power shall

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be provided to essential equipment in treatment areas and patient bedrooms.

(iii) Fuel shall be stored at the facility sufficient to provide seventy-two (72) hours of continuous operation.

(QQ) Telephone Systems. A telephone system shall be provided that is sufficient to meet the needs of the recovery care center's staff and patients.

(RR) Enclosed carts shall be used for transportation and handling of materials.

(SS) Prior to the licensure of the center all electrical, mechanical and fire protection systems, equipment, appliances and biomedical equipment shall be tested, balanced and operated to demonstrate that the installation and performance of these systems conform to the requirements of the plans and specifications.

(4) Operations, maintenance and housekeeping

(A) Maintenance, safety and sanitation

(i) The center shall be equipped, operated and maintained so as to sustain its safe, clean and sanitary characteristics and to minimize all health hazards. Maintenance shall include provision and surveillance of services and procedures for the safety and well-being of patients, personnel and visitors.

(ii) Buildings and grounds shall be maintained free of environmental pollutants and such nuisances as may adversely affect the health or welfare of patients to the extent that conditions are within the reasonable control of the recovery care center.

(iii) A written manual on the maintenance of all heating, mechanical, alarm, air conditioning and ventilation, communication, biomedical equipment and fire protection systems shall be adopted and implemented.

(iv) Maintenance logs of services performed on the equipment shall be retained for review in the recovery care center for a minimum of five (5) years.

(v) Air conditioning and ventilation systems shall be inspected and maintained in accordance with the written maintenance schedule to ensure that a properly conditioned air supply, meeting minimum filtration, humidity, and temperature requirements, is provided.

(B) Housekeeping

(i) The recovery care center shall set forth and implement written housekeeping procedures and ensure adequate numbers of housekeeping personnel to implement the program. (ii) The supervisor of housekeeping shall coordinate housekeeping activities with safety and infection control programs.

(iii) The procedures of housekeeping shall minimally provide for the use, care and cleaning of equipment; selection and use of supplies; completion of cleaning schedules; evaluation of cleaning effectiveness; and maintenance of a clean and sanitary environment.

(5) Emergency preparedness plan

(A) The recovery care center shall have a written emergency preparedness plan that includes procedures to be followed in case of medical emergencies, or in the event that all or part of the building becomes uninhabitable because of a natural or other disaster. The fire plan component shall be submitted to the local fire marshal for comment prior to its adoption.

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(B) The emergency preparedness plan shall specify the following procedures:

- (i) identification and notification of appropriate persons;
- (ii) instructions as to locations and use of emergency equipment and alarm systems;
- (iii) tasks and responsibilities assigned to all personnel;
- (iv) evacuation routes;
- (v) procedures and arrangements for alternative site relocation or evacuation of patients;
- (vi) transfer of casualties;
- (vii) transfer of records;
- (viii) care of patients; and
- (ix) handling of drugs and biologicals.

(C) A copy of the fire plan shall be maintained on each nursing station and in each service area. Fire evacuation plans shall be conspicuously posted in the corridor of each fire zone.

(D) All personnel shall receive training in emergency preparedness as part of their employment orientation, and annually thereafter. Staff shall be required to read and acknowledge by signature their understanding of the emergency preparedness plan as part of the orientation. The content and participants of the training orientation shall be documented in writing.

(E) Drills testing the effectiveness of the fire plan shall be conducted on each shift at least four (4) times per year. A written record of each drill, including the date, hour, description of drill, and signatures of participating staff and the person in charge shall be maintained by the facility.

(Adopted effective March 2, 1995)

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Subject

Strike Contingency Plans for Health Care Facilities

Section

§ 19a-497-1

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Sec. 19a-497-1. Strike contingency plans for health care facilities

Strike Contingency Plans for Health Care Facilities

Sec. 19a-497-1. Strike contingency plans for health care facilities

(a) Upon receipt of notice of an anticipated strike action, a health care institution, as defined in Section 19a-490 of the Connecticut General Statutes, shall immediately notify the Department of Public Health of such anticipated action and provide the Department with a copy of the strike notice.

(b) A strike contingency plan shall be submitted to the Department pursuant to Section 19a-497 of the Connecticut General Statutes. Such plan shall be filed with the Department as soon after a health care institution receives notification of a strike as possible but in no event later than five (5) calendar days prior to the date set forth for the strike in the notice received by the health care institution.

(c) The strike contingency plan for hospitals and any satellite locations of such hospitals shall contain the following information:

(1) Name, address and licensed capacity of the hospital and any satellite locations of such hospital;

(2) Name of labor organization that has notified the facility of its intention to strike;

(3) Date and time the strike is expected to occur;

(4) Categories and numbers of personnel expected to strike at each site;

(5) Names, addresses and telephone numbers of the following: president, administrator, medical director, medical staff, director of nurses, assistant director of nurses, maintenance supervisor;

(6) Names and emergency telephone numbers of the following:

(A) Local fire department;

(B) Local police department;

(C) Local director of health;

(D) Utility companies: (gas, water, electricity, telephone);

(E) Ambulance service;

(F) Closest hospital able to admit patients or clients in case of an emergency;

(G) All providers of basic services to the facility (i.e., oxygen service, emergency generator repair service, fuel supplier, electrical and plumbing service, suppliers or vendors of food and provisions, linen, pharmaceutical and medical supplies);

(H) Staff person charged with overall coordination of the facility's services during the strike; and

(I) The chair of the board of directors and the chief executive officer;

(7) Description of plans for the provision of professional and support services during the strike;

(8) Security measures specific to strike activities;

(9) Plan for orientation and training of replacement staff in emergency procedures related to the facility's patients or clients prior to the replacement staff assuming duties; and

(10) Plan for assuring access of patients or clients, personnel, visitors and vendors to and from the facility during the strike including special security arrangements to assure

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their safety and facility safety.

(d) The strike contingency plan for nursing homes, residential care homes, residential alcohol or drug treatment facilities and infirmaries in educational institutions shall contain the following information:

- (1) Name, address, licensure category and licensed capacity of the facility;
- (2) Name of labor organization that has notified the facility of its intention to strike;
- (3) Date and time the strike is expected to occur;
- (4) Categories and numbers of personnel expected to strike;
- (5) Names, addresses and telephone numbers of the following: facility owner, administrator, medical director, medical staff, director of nurses, assistant director of nurses, maintenance supervisor;
- (6) Names and emergency telephone numbers of the following:
 - (A) Local fire department;
 - (B) Local police department;
 - (C) Local director of health;
 - (D) Utility companies: (gas, water, electricity, telephone);
 - (E) Ambulance service;
 - (F) Closest hospital able to admit patients or clients in case of an emergency;
 - (G) All providers of basic services to the facility (i.e., oxygen service, emergency generator repair service, fuel supplier, electrical and plumbing service, suppliers or vendors of food and provisions, linen, pharmaceutical and medical supplies);
 - (H) Staff person charged with overall coordination of the facility's services during the strike; and
 - (I) The chair of the board of directors and the chief executive officer;
- (7) Current patient or client census;
- (8) Numbers and diagnoses of patients or clients by unit;
- (9) Procedure by which to notify patients or clients and their family, guardians or conservators of the impending strike;
- (10) Staffing patterns, by shift, for all services which the facility intends to maintain during the strike;
- (11) Names and titles of all facility staff, by assignment and shift, who will be on duty during the strike;
- (12) Sources of any additional personnel that may be necessary to meet the staffing patterns described in subdivision (10) of this subsection;
- (13) Plan for orientation and training of replacement staff in emergency procedures related to the facility or the facility's patients or clients prior to the replacement staff assuming duties;
- (14) Plan for update of patient care plans, discharge plans and W-10 transfer forms;
- (15) Any changes in the tasks and responsibilities assigned to personnel, which meet all applicable state and federal requirements, including, but not limited to, changes to nursing, dietary, maintenance functions for which such personnel have been trained, shall be

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identified in the strike contingency plan;

(16) If a reduction of patient or client census is anticipated, the names and types of health care facilities which will admit transferred patients or clients during the strike;

(17) Plan for assuring access of patients or clients, personnel or visitors to and from the facility during the strike including special security arrangements to assure their safety and facility safety;

(18) An adequate inventory of at least a one week supply of pharmaceutical and medical supplies. If additional supplies are needed to meet the one week minimum standard, a copy of the supply order shall be attached to the strike contingency plan;

(19) An adequate inventory of at least a one week supply of food and provisions. If additional supplies are needed to meet the one week minimum standard, a copy of the supply order shall be attached to the strike contingency plan;

(20) An adequate inventory of at least a one week supply of linens, laundry, dishwashing and cleaning supplies. If additional supplies are needed to meet the one week minimum standard, a copy of the supply order shall be attached to the strike contingency plan;

(21) An adequate inventory of at least a one week supply of fuel. If additional fuel is needed to meet the one week minimum standard, a copy of the supply order shall be attached to the strike contingency plan; and

(22) A detailed plan for the delivery of supplies as identified in subdivisions (18) to (21) of this subsection and for the provision of alternate delivery sites if vendors choose not to cross the picket line.

(e) The strike contingency plan for outpatient clinics operated by a corporation or municipality shall contain the following information:

(1) Name, address, and licensure category of the facility;

(2) Name of labor organization that has notified the facility of its intention to strike;

(3) Date and time the strike is expected to occur;

(4) Categories and numbers of personnel expected to strike;

(5) Names, addresses and telephone numbers of the following: president, administrator, medical director, medical staff, nursing staff;

(6) Names and emergency telephone numbers of the following:

(A) Local fire department;

(B) Local police department;

(C) Local director of health;

(D) Utility companies: (gas, water, electricity, telephone);

(E) Ambulance service;

(F) Closest hospital able to care for patients in case of an emergency;

(G) All providers of basic services to the facility (i.e., oxygen service, emergency generator repair service, fuel supplier, electrical and plumbing service, suppliers or vendors of linen, pharmaceutical and medical supplies);

(H) Staff person charged with overall coordination of the facility's services during the strike; and

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- (I) The chair of the board of directors and the chief executive officer;
 - (7) Current patient or client caseload;
 - (8) Procedure by which to notify patients or clients and their families, guardians or conservators of the impending strike;
 - (9) Staffing patterns, by shift, for all services which the facility intends to maintain during the strike;
 - (10) Names and titles of all facility staff, by assignment and shift, who will be on duty during the strike;
 - (11) Plan for orientation and training of replacement staff in emergency procedures related to the facility or the facility's patients or clients prior to the replacement staff assuming duties;
 - (12) Any changes in the tasks and responsibilities assigned to personnel, which meet all applicable state and federal requirements, including, but not limited to, changes to nursing, dietary and maintenance functions for which such personnel have been trained, shall be identified in the strike contingency plan;
 - (13) If a reduction in caseload or services is anticipated, the names and types of facilities which will provide service to these patients or clients during the strike, and plans for transmitting information on the care or services to be provided;
 - (14) Plan for assuring access of patients or clients, personnel, vendors and visitors to and from the facility during the strike;
 - (15) Description of special security arrangements to assure patient or client, staff, vendors, visitors and facility safety;
 - (16) An adequate inventory of at least a one week supply of pharmaceutical and medical supplies. If additional supplies are needed to meet the one week minimum standard, a copy of the supply order shall be attached to the strike contingency plan;
 - (17) An adequate inventory of at least a one week supply of linens, laundry, dishwashing and cleaning supplies. If additional supplies are needed to meet the one week minimum standard, a copy of the supply order shall be attached to the strike contingency plan;
 - (18) An adequate inventory of at least a one week supply of fuel. If additional fuel is needed to meet the one week minimum standard, a copy of the supply order shall be attached to the strike contingency plan; and
 - (19) A plan that shall describe the operation of the professional and support services during the strike including the mechanism utilized to inform individuals of the potential strike and the provisions to ensure professional and support services are maintained.
- (f) The strike contingency plan for home health care agencies and homemaker-home health aide agencies shall contain the following information:
- (1) Name and address of the agency;
 - (2) Name of labor organization that has notified the agency of its intention to strike;
 - (3) Date and time the strike is expected to occur;
 - (4) Categories and numbers of personnel expected to strike;
 - (5) Names, addresses and telephone numbers of the following: agency owner;

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administrator; supervisor of clinical services; and other supervisory personnel;

(6) Names and emergency telephone numbers of the following:

(A) Local director of health;

(B) Staff person charged with overall coordination of the agency's services during the strike; and

(C) The chair of the board of directors and the chief executive officer of the agency;

(7) Current patient caseload;

(8) Numbers and diagnosis of critical and unstable patients;

(9) Procedure by which to notify patients and their family, guardians or conservators of the impending strike;

(10) Staffing patterns, by shift, for all services which the agency intends to maintain during the strike;

(11) Names and titles of all agency staff, by assignment and shift, who will be on duty during the strike;

(12) Sources of any additional personnel that may be necessary to meet the staffing pattern described in subdivision (10) of this subsection;

(13) Plan for orientation of replacement staff to the agency's policies and patient caseload and training in emergency procedures related to the agency or patients prior to the replacement staff assuming duties;

(14) Plan for update of patient care plans, discharge plans and W-10 transfer forms;

(15) Any changes in tasks and responsibilities assigned to personnel;

(16) If a reduction of patient caseload is anticipated, the names, telephone numbers and types of health care facilities which will admit transferred patients during the strike;

(17) Plans for assuring access of staff or visitors to and from the agency during the strike;

(18) Description of special security arrangements to assure staff safety during the strike; and

(19) Description of plans for the operation of professional and support services during the strike.

(g) Each institution as defined in section 19a-490 of the Connecticut General Statutes shall be subject to a civil penalty pursuant to section 19a-497 of the Connecticut General Statutes for noncompliance with any provision of Connecticut General Statutes section 19a-497 including, but not limited to:

(1) The failure to submit a strike contingency plan to the Department of Public Health not later than five (5) days prior to the indicated strike date;

(2) The failure of the plan to include documentation as required by this section of the Regulations of Connecticut State Agencies; and

(3) The failure of the plan to meet the needs of the population served by the institution in any respect including, but not limited to, any of the following:

(A) adequate staffing;

(B) security;

(C) pharmaceuticals;

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(D) essential supplies, including, but not limited to, food, fuel and medical supplies; and
(E) necessary services to meet the needs of the patient population served by the institution in the event of a strike.

(Effective August 17, 1983; Amended July 3, 2007; Amended April 12, 2011)

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Discharge Planning

Section

§ 19a-504c-1

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Sec. 19a-504c-1. Discharge planning

Discharge Planning

Sec. 19a-504c-1. Discharge planning

(a) Every hospitalized patient shall have a written discharge plan, which shall be given to the patient or family or representative prior to discharge.

(b) The discharge plan shall include but not necessarily be limited to identification of the patient's needs for continued skill care or support services, and the specific resources to be utilized to meet these needs.

(c) The discharge plan must be completed on a timely basis so that appropriate arrangements for post hospital care management are made before discharge.

(d) The discharge plan is to be developed in collaboration with the patient, or appropriate family or representative and other care givers.

(e) The discharge plan shall be approved by the physician of record.

(f) The written discharge plan must be signed by the patient and/or family member or representative indicating their understanding of the discharge plan of care.

(g) The documentation of the written discharge plan shall be retained as a permanent part of the patient's medical record.

(h) Information necessary to ensure the continuity of care will be sent to participating providers, as appropriate, a copy of which will be retained as a permanent part of the patient's medical record.

(Effective September 25, 1989)

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Subject

Maternity Homes

Inclusive Sections

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Sec. 19a-506-1—19a-506-6. Repealed

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Maternity Homes

Sec. 19a-506-1—19a-506-6. Repealed

Repealed February 23, 2011.

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Nursing Home Administrator—Educational & Licensure Requirements

Inclusive Sections

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Nursing Home Administrator—Educational & Licensure Requirements

Sec. 19a-519-1. Definitions

As used in these regulations, the following terms shall have the meanings specified.

(a) “Accredited institution of higher education” means an institution which has received accreditation to grant post-secondary degrees from one of the following regional accrediting bodies: New England Association of Schools and Colleges; Middle States Association of Colleges and Schools; North Central Association of Colleges and Schools; Northwest Association of Schools and Colleges; Southern Association of Colleges and Schools; and Western Association of Schools and Colleges.

(b) “Commissioner” means the Commissioner of Health Services or his designee.

(c) “Department” means the Department of Health Services.

(d) “Program director” means the individual responsible for developing and administering an approved educational and training program at an accredited institution of higher education.

(e) “Business Affiliation” means having a financial, or personal beneficial, interest in or having any type of employment or contractual relationship with the long-term care facility or hospital within the two years immediately preceding the beginning of the residency training.

(f) “Familial Affiliation” means having a spouse, child, child’s spouse, parent, brother, or sister who is either an officer, director, owner, limited or general partner, or holds more than 5% of outstanding stock in a facility.

(g) “Applying for licensure” means submitting a completed application and such supporting documentation as are sufficient to satisfy licensure eligibility requirements as determined by the Department.

(Effective October 30, 1987)

Sec. 19a-519-2. Course in long-term care administration

A course in long term care administration, as used in Section 19a-512 of the Connecticut General Statutes, shall consist of two components: academic instruction in long term care administration and residency training in long term care administration.

(a) A course in long term care administration offered by an educational institution in Connecticut must be approved pursuant to Section 19a-519-4 of these regulations.

(b) The academic component of a course in long term care administration shall consist of a minimum of three (3) semester credit hours, or equivalent, of academic instruction in Administration and Management of Long Term Care Facilities within an accredited institution of higher education and shall include the following content areas: General Administration and Management of Long Term Care Facilities; Financial Management of Long Term Care Facilities; Laws and Regulations Governing Long Term Care Facilities; Personnel Management and Labor Relations in Long Term Care Facilities; Patient Care and Services; Long Term Care Planning and Delivery Systems; and Gerontology.

(c) The residency training in long term care administration, also referred to as the one

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year residency period required by Connecticut General Statutes Section 19a-512 (a) (2), shall consist of a program of at least nine hundred (900) clock hours of administrative training in a long-term care facility providing skilled nursing care twenty-four hours per day under medical supervision and direction, and shall be completed under the joint supervision and direction of a licensed nursing home administrator in such facility and the program director.

Such program shall include the following areas of experience: Administration, including Business Office, Human Resources, Management Information Processing, Marketing, Planning and Public Relations; Staff Development; Nursing Services; Medical and Professional Services; Rehabilitative Services, including Physical Therapy, Occupational Therapy, and Speech Therapy; Social Services; Medical Records; Recreation Therapy; Dietetics; and Physical Plant, including Maintenance, Housekeeping, Central Supply, and Laundry.

(d) In all cases, the trainee must receive approval of residency training from the program director prior to beginning the training. A minimum of four hundred fifty (450) clock hours of residency training shall be completed in a long-term care facility with which the trainee has no business or familial affiliation. Upon the prior written approval of the program director, the remaining four hundred fifty (450) clock hours can be completed in a facility where a business or familial affiliation does exist. A minimum of twenty (20) hours of residency training must be completed each week.

(e) The residency training shall not commence prior to the approved academic instruction. The residency training may commence concurrent with the approved academic instruction with the prior written approval of the program director.

(Effective October 30, 1987)

Sec. 19a-519-3. Masters' degree requirements

(a) A master's degree program offered by an educational institution in Connecticut for Nursing Home Administrator licensure in Connecticut must be approved pursuant to Section 19a-519-4 of these regulations.

(b) The master's degree referenced in Connecticut General Statutes Section 19a-512 (b) (2) (B) shall either be accredited by the Accrediting Commission On Education For Health Services Administration or consist of: (1) a minimum of forty-five (45) semester hours of graduate level study completed in an accredited institution of higher education. A minimum of fifteen (15) of the forty-five (45) semester hours shall be classroom instruction within the area of health care administration. The coursework in health care administration shall include, but not necessarily be limited to, the following areas of administration of health care facilities: General Administration and Management of Health Care Facilities; Laws and Regulations Governing Health Care Facilities; Financial Management; Personnel Management and Labor Relations; Patient Care and Services; Health Care Planning and Delivery Systems; and Gerontology; and (2) a supervised field experience of at least five hundred (500) clock hours of training in the overall operation and administration of a

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hospital providing inpatient medical services or of a long term care facility providing skilled nursing care twenty-four hours per day under medical supervision and direction. Such experience shall be obtained in a facility with which the trainee has no business or familial affiliation.

(Effective May 21, 1990)

Sec. 19a-519-4. Program approval

Program approval shall be administered as follows:

(a) Initial approval shall be granted to a program in the following manner:

(1) The program shall provide to the Commissioner:

(A) Written notice of intent to seek program approval;

(B) A feasibility study for the planned program, which shall include discussion of at least the following:

(i) Applicant pool;

(ii) Graduate employment opportunities;

(iii) Educational and training facilities to be utilized;

(iv) Funding sources to be utilized

(C) A plan for the employment of program director and faculty. The plan shall specify the numbers and types of staff to be employed, the requisite qualifications of such staff, the timelines for employment of such staff, and projected future staffing needs.

(D) A comprehensive plan for the development and implementation of the educational program, including admission policies, educational objectives, curricula, course outlines, course sequences, graduation requirements, staffing, residency training or field experience sites, residency training or field experience supervisors, timelines, and a systematic self-evaluation plan;

(E) Any other information that the Commissioner may reasonably request.

(2) Pending satisfactory reviews of the program's educational standards, such initial approval shall remain in effect until the results of the first two licensure exams for program participants are available. However, the Commissioner shall have the discretion to conduct an earlier re-evaluation of program approval status should educational deficiencies become apparent during the period of initial approval.

(3) Acceptable program graduate performance shall be defined as at least an average of 80% of all program graduates who take the exam within any one year period successfully passing the licensing exam.

(4) Initial approval can only be retained for a maximum of eighteen months from the date of first program graduate.

(5) Conditional approval may be granted for one year to a program previously having initial or full approval if:

(A) The graduates of the program fail to achieve the standards prescribed in subsection (a) (3) of this section; or

(B) The program has initiated a major change from the approved plan pursuant to

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subsection (d) of this section.

(C) The program is not administered in a manner consistent with these regulations.

(6) Special progress reports shall be required of programs under conditional approval status.

(b) Full approval is granted by the Commissioner after the initial or conditional approval based on evidence that the program is meeting its educational objectives as demonstrated by graduates' performance, as defined in subsection (a) (3) of this section and that the program has maintained compliance with these regulations.

(c) The Commissioner, after a hearing, may remove a program from the list of approved programs when:

(1) The program has been on conditional approval for at least one year and has failed to correct identified deficiencies which caused it to be placed on conditional status;

(2) The Commissioner provides written notice of such hearing to the program director setting forth the particular reasons for the proposed action and fixing a date, not less than thirty days from the date of such written notice, at which time representatives of the program will have an opportunity for a hearing;

(3) Upon completion of the hearing, the commissioner makes a decision regarding what action should be taken regarding the program;

(d) When a change is sought in the program director, faculty, curriculum or training experiences, the previously approved program must remain in place until the new program is approved by the Commissioner. Notice of such change shall be sent to the Commissioner accompanied by:

(1) Rationale for change;

(2) Concise presentation of current vs. proposed program;

(3) Explanation of the effects of changes on:

(i) Currently enrolled students;

(ii) Functions and roles of graduates of new program.

(4) Timetable for implementation of change.

(Effective October 30, 1987)

Sec. 19a-519-5. Repealed

Repealed May 21, 1990.

Sec. 19a-519-6. Licensure of applicants licensed in other states

(a) Applicants seeking Connecticut licensure under this section shall be currently licensed competent nursing home administrators in good standing in another state.

(b) Applicants under this section who have completed an administrator training program approved by the appropriate regulatory body of another state and equal to the training program required in this state may have that training accepted in lieu of the approved residency training requirement of Section 19a-519-2 of these regulations.

(c) Applicants under this section who have not completed an approved training program

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may have their licensed work experience accepted in lieu of the approved residency training requirement if they have been licensed and working full-time as the administrative head of a long term care facility providing skilled nursing services twenty four hours per day under medical supervision and direction for at least one year in such other state.

(d) Applicants under this section who hold a master's degree which lacks either course work or supervised field experience requirements may take supplemental coursework or supervised field experience to address those deficiencies. Such supplemental coursework or supervised field experience shall be approved in advance by the Department.

(Effective October 30, 1987)

Sec. 19a-519-7. Reinstatement

A person previously licensed as a Nursing Home Administrator whose license has become void may apply for licensure pursuant to the provisions of Sections 19a-14-1 to 19a-14-5, inclusive, of the Regulations of Connecticut State Agencies.

(Effective October 30, 1987)

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Civil Penalty Violations for Chronic and Convalescent Nursing Homes and Rest Homes with Nursing Supervision

Sec. 19a-527-1. Classification of civil penalty violations of regulations for chronic and convalescent nursing homes and rest homes with nursing supervision

Any rest home with nursing supervision or chronic and convalescent nursing home as defined in section 19a-521 of the Connecticut General Statutes found by the Commissioner of Public Health to be in violation of one of the following provisions of the Regulations of Connecticut State Agencies shall be subject to the class of violation indicated below and penalties indicated in section 19a-527 of the Connecticut General Statutes:

(a) A violation of any of the following regulatory provisions shall result in a Class A violation:

- (1) 19-13-D8t (j) (2) (L);
- (2) 19-13-D8t (n) (6);
- (3) 19-13-D8t (v) (2) (B);
- (4) 19-13-D8t (v) (2) (C) (i); (iii);
- (5) 19-13-D8u (b);
- (6) 19-13-D8u (c) (2);

(b) A violation of any of the following regulatory provisions shall result in a Class B violation:

- (1) 19-13-D8t (d) (3);
- (2) 19-13-D8t (e) (1);
- (3) 19-13-D8t (f) (3);
- (4) 19-13-D8t (h) (1); (2);
- (5) 19-13-D8t (j) (1);
- (6) 19-13-D8t (j) (2), (A); (D); (I);
- (7) 19-13-D8t (m) (1);
- (8) 19-13-D8t (m) (2);
- (9) 19-13-D8t (m) (4);
- (10) 19-13-D8t (m) (5); (6);
- (11) 19-13-D8t (m) (7); (8);
- (12) 19-13-D8t (n) (1);
- (13) 19-13-D8t (n) (2);
- (14) 19-13-D8t (n) (3);
- (15) 19-13-D8t (n) (5);
- (16) 19-13-D8t (n) (7);
- (17) 19-13-D8t (q) (2) (A); (C);
- (18) 19-13-D8t (t) (2); (3);
- (19) 19-13-D8t (u) (2); (4);
- (20) 19-13-D8t (v) (3);
- (21) 19-13-D8t (v) (15) (A);
- (22) 19-13-D8t (v) (16) (D) (ii);

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- (23) 19-13-D8t (v) (17) (E) (i);
- (24) 19-13-D8t (v) (18) (B);
- (25) 19-13-D8t (v) (20) (B); (C);
- (26) 19-13-D8u (c) (1) (C) (i).

(Effective March 1, 1988; Amended July 3, 2007)

Sec. 19a-527-2. Classification of violations of statutes by a nursing home facility

Any nursing home facility as defined in section 19a-521 of the Connecticut General Statutes found by the Commissioner of Public Health to be in violation of one of the following provisions of the Connecticut General Statutes shall be subject to the class of violation indicated below and penalties indicated in section 19a-527 of the Connecticut General Statutes:

(a) A violation of any of the following statutory provisions shall result in a Class A violation:

- (1) 19a-535 (c);
- (2) 19a-555 (c);

(b) A violation of any of the following statutory provisions shall result in a Class B violation:

- (1) 19a-535 (a);
- (2) 19a-550 (a) (8);
- (3) 19a-550 (a) (18);
- (4) 19a-555 (a);
- (5) 19a-555 (b);
- (6) 19a-555 (d).

(c) A violation of the following statutory provision shall result in a civil penalty of not more than ten thousand dollars for each day of non-compliance:

- (1) 19a-497

(d) A violation of the following statutory provision shall result in a civil penalty in an amount determined by the commissioner in accordance with section 19a-527 and section 19a-528 of the Connecticut General Statutes:

- (1) 17b-406

(Effective March 1, 1988; Amended July 3, 2007)

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Agency

Department of Public Health

Subject

Recognition and Transfer of “Do Not Resuscitate” Orders

Inclusive Sections

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Recognition and Transfer of “Do Not Resuscitate” Orders

Sec. 19a-580d-1. Definitions

As used in sections 19a-580d-1 through 19a-580d-9 of the Regulations of Connecticut State Agencies:

(1) “Attending physician” means the Connecticut licensed physician selected by or assigned to a patient, who has primary responsibility for the treatment and care of the patient. Where more than one physician shares such responsibility, any such physician may act as the attending physician.

(2) “Authorized representative” means a person who is otherwise authorized by law to provide consent to the issuance or revocation of a DNR order for an incapable or incompetent patient.

(3) “Department” means the Connecticut Department of Public Health.

(4) “Designated agency” means either a healthcare institution or a physician licensed by the department.

(5) “Do Not Resuscitate order” or “DNR order” means an order written by a Connecticut licensed physician to withhold cardiopulmonary resuscitation, including chest compressions, defibrillation, or breathing or ventilation by any assistive or mechanical means including, but not limited to, mouth-to-mouth, mouth-to-mask, bag-valve mask, endotracheal tube, or ventilator for a particular patient.

(6) “DNR bracelet” means the bracelet approved by the department for the transmission of a ‘Do Not Resuscitate’ order and meeting the requirements of section 19a-580d-4.

(7) “DNR transfer form” means a form approved by the department for the transmission of a ‘Do Not Resuscitate’ order issued by a licensed physician.

(8) “Emergency Medical Services provider” or “EMS Provider” means a person, association, or organization who provides immediate or life saving transportation and medical care away from a hospital to a victim of sudden illness or injury, and who may also provide invalid coach services.

(9) “Healthcare institution” means an institution licensed or regulated under chapter 368v of the Connecticut General Statutes.

(10) “Medical direction” means the provision of medical advice, consultation, instruction and authorization to appropriately trained or certified personnel by designated staff members at sponsor hospitals.

(Adopted effective December 30, 1996)

Sec. 19a-580d-2. DNR transfer form

(a) To transmit a DNR order between healthcare institutions or during transport by an EMS provider between healthcare institutions, the DNR order shall be documented on the DNR transfer form.

(b) The DNR transfer form signed by a licensed physician or a registered nurse shall be

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recognized as such and followed by healthcare institutions and EMS providers.

(Adopted effective December 30, 1996)

Sec. 19a-580d-3. Transfer and recognition of DNR orders when patients are transported

(a) When a patient who is to be transferred between healthcare institutions has a DNR order which is to remain in effect during and after the transfer, that order shall be documented on a DNR transfer form which is signed by the physician who entered the DNR order or by a registered nurse who attests to the existence of such order. The DNR transfer form or a legible copy shall be sent with the patient when the patient is transferred to another healthcare institution.

(b) The DNR transfer form or a legible copy shall be retained with the patient's medical record.

(c) The DNR transfer form or a legible copy or a DNR bracelet shall be shown to all EMS providers by the healthcare facility staff person who transfers care of the patient to the EMS providers. The EMS provider shall show the DNR transfer form or a legible copy or a DNR bracelet to a nurse or physician at the receiving healthcare institution or, in the absence of a nurse or physician, the person in charge of patient care.

(d) Any healthcare institution receiving a patient with a DNR transfer form, a legible copy, or DNR bracelet shall honor the DNR order until such time as admitting orders are written in accordance with the healthcare institution's policies.

(e) When a patient has a DNR order which is to remain in effect after discharge from a healthcare institution to home, that patient shall be offered a DNR bracelet by the healthcare institution prior to discharge.

(f) Any EMS provider receiving a patient with a DNR transfer form or a legible copy or a DNR bracelet shall honor the DNR order.

(Adopted effective December 30, 1996)

Sec. 19a-580d-4. DNR bracelets

(a) A DNR bracelet shall be the only valid indication recognized by EMS providers that a DNR order exists for patients outside a healthcare institution, other than those patients received by an EMS provider directly from a healthcare institution. A valid DNR bracelet shall:

- (1) Be of a design approved by the department,
- (2) be affixed to the patient's wrist or ankle,
- (3) display the patient's name and attending physician's name, and
- (4) not have been cut or broken at any time.

(b) A DNR bracelet shall be recognized and honored by healthcare institutions and EMS providers.

(c) A patient or the patient's authorized representative may obtain a DNR bracelet from any designated agency based on a written order from the patient's attending physician.

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(1) The designated agency shall maintain a permanent record including a copy of the written DNR order.

(2) A designated agency may obtain DNR bracelets and DNR transfer forms from the organization selected by the department to maintain a central supply of such items.

(Adopted effective December 30, 1996)

Sec. 19a-580d-5. DNR patients under the care of EMS providers

DNR patients under the care of EMS providers shall be given medical care as determined by consultation with medical direction, recognizing the limitations of the DNR order.

(Adopted effective December 30, 1996)

Sec. 19a-580d-6. Assistance by attending physicians

When requested by a patient or his authorized representative the attending physician who issued the DNR order shall:

- (a) Provide the patient with information on how to contact a designated agency, or
- (b) if a patient is unable to obtain a DNR bracelet from any other source, the attending physician shall obtain and provide one.

(Adopted effective December 30, 1996)

Sec. 19a-580d-7. Revocation

A DNR order may be revoked by the patient or authorized representative in any of the following ways:

- (a) Removing the bracelet from the patient's extremity, or
- (b) telling an individual licensed healthcare provider or certified emergency medical technician. Such healthcare provider or emergency medical technician shall enter, or cause to be entered, the contents of the statement in the patient's permanent medical record and notify the attending physician and the physician who issued the DNR order.

(Adopted effective December 30, 1996)

Sec. 19a-580d-8. Provision for patients with certain considerations

(a) Nothing in these regulations shall be construed to limit the authority of the commissioner of mental retardation under subsection (g) of section 17a-238 of the general statutes concerning orders applied to persons receiving services under the direction of the commissioner of mental retardation.

(Adopted effective December 30, 1996)

Sec. 19a-580d-9. Ethical, philosophical, religious objections

(a) Healthcare providers who have an ethical or philosophical, or religious objection to implementing a DNR order shall turn over care of the patient without delay to another provider who will implement the DNR order. Pending the assumption of care by another

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provider, the DNR order shall be followed.

(Adopted effective December 30, 1996)

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Informed Consent for an HIV-Related Test

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Sec. 19a-586-2.	Written informed consent required
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Informed Consent for an HIV-Related Test

Sec. 19a-586-1. Definitions

As used in Sections 19a-586-1 to 19a-586-3, inclusive:

- (a) “Commissioner” means the Insurance Commissioner;
- (b) “AIDS” means acquired immune deficiency syndrome, as defined by the Centers for Disease Control of the United States Public Health Service;
- (c) “HIV infection” means infection with the human immunodeficiency virus or any other related virus identified as a probable causative agent of AIDS; and
- (d) “HIV-related test” means any laboratory test or series of tests for any virus, antibody, antigen or etiologic agent whatsoever thought to cause or indicate the presence of HIV infection.

(Effective December 21, 1992)

Sec. 19a-586-2. Written informed consent required

(a) Any insurer or health care center that requests an applicant for insurance coverage to take an HIV-related test shall obtain the applicant’s written informed consent for such test at the time of application for such insurance. No such test may be conducted unless the insurer or health care center has first obtained such consent.

(b) The informed consent form used by insurers and health care centers shall be in the standardized format described in Sec. 19a-586-3, provided any insurer or health care center may use a form which does not conform to said section if, prior to using it, (1) the alternate form is filed with the Commissioner and (2) the insurer or health care center certifies to the Commissioner that the form includes all the information contained in the standard form and is not inaccurate, misleading or inconsistent with any applicable statute or regulation. The certification shall be filed in such form and manner as is prescribed by the Commissioner, and shall be signed by an officer of the insurer or health care center.

(Effective December 21, 1992)

Sec. 19a-586-3. Standardized informed consent form

The standard form to be used by insurers in obtaining applicants’ informed consent pursuant to Sec. 19a-586-2, which in the case of use by a health care center as defined in Sec. 38a-175 of the General Statutes, all references to “insurer” shall be changed to “health care center,” is as follows:

NOTICE AND CONSENT FORM FOR AIDS VIRUS (HIV) ANTIBODY/ANTIGEN
TESTING

Insurer: (Name and Address)

Examiner: (Name and Address)

Acquired Immunodeficiency Syndrome (AIDS) is a life-threatening disorder of the immune system. It is caused by a virus called Human Immunodeficiency Virus (HIV). The virus is spread by sexual contact with an infected person, by exposure to infected blood (as in needle sharing during intravenous drug use or, rarely, as a result of a blood transfusion),

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or from an infected mother to her newborn infant.

To determine your insurability, the insurer named above (the Insurer) has requested that you provide a sample of your blood for testing and analysis. All tests will be performed by a licensed laboratory.

Unless precluded by law, tests will be performed to determine the presence of HIV antibodies or antigens. The HIV antibody test that we perform is actually a series of tests done by a medically accepted procedure. The HIV antigen test directly identifies AIDS viral particles. These tests are extremely reliable. Should you desire more information about the test of HIV infection before providing a blood sample, you may wish to consult with your physician or your local health department. If you are at high risk of HIV infection, you may want to be counseled and tested by your physician or at a free/low cost local test site. Your local health department can provide you with information as to the location of these sites.

All tests results will be treated confidentially. They will be reported by the laboratory to the insurer. When necessary for business reasons in connection with insurance you have or have applied for with the Insurer, the Insurer may disclose test results to others such as its affiliates, reinsurers, employees or contractors, but not to agents and brokers.

If the Insurer is a member of the Medical Information Bureau (MIB, Inc.), and if the test results for HIV antibodies/antigens are other than normal, the Insurer will report to the MIB, Inc. a generic code which signifies only a non-specific blood test abnormality. If your HIV test is normal, no report will be made about it to the MIB, Inc.

The organizations described in the last two paragraphs may maintain the test results in a file or data bank. There will be no other disclosure of test results or even that the tests have been done except as may be required or permitted by law or as authorized by you.

If your HIV test results are normal, no routine notification will be sent to you. If the HIV test results are other than normal, the Insurer will contact you. The Insurer may ask you for the name of a physician or other health care provider to whom you may authorize disclosure and with whom you may wish to discuss the results.

Positive HIV antibody/antigen test results do not mean that you have AIDS, but that you are at significantly increased risk of developing AIDS or AIDS-related conditions. Federal authorities say that persons who are HIV antibody/antigen positive should be considered infected with the AIDS virus and capable of infecting others.

Positive HIV antibody or antigen test results or other significant blood abnormalities will adversely affect your application for insurance. This means that your application may be declined, that an increased premium may be charged, or that other policy changes may be necessary.

You are urged, at this time, to designate the physician or other health care provider to whom the HIV test results may be disclosed by the Insurer in the event the results are other than normal.

I authorize the disclosure of any HIV test results which are other than normal to the following physician or health care provider:

Name _____ Address _____

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Zip Code _____

I have read and understand this Notice of Consent for AIDS Virus (HIV) Antibody/Antigen Testing. I voluntarily consent to the withdrawal of blood from me by needle, the testing of that blood, and the disclosure of the test results as described above.

I understand that I have the right to request and receive a copy of this authorization. A photocopy of this form will be as valid as the original.

Proposed Insured

Date of Birth

Signature of Proposed Insured
or Parent/Guardian

State of Residence

Date

(Effective December 21, 1992)

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Subject

Aids Related Testing and Medical Information and Confidentiality

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Aids Related Testing and Medical Information and Confidentiality

Sec. 19a-589-1. Definitions

As used in sections 19a-589-1 through 19a-589-3 inclusive as follows:

(a) “AIDS” means acquired immune deficiency syndrome, as defined by the Centers for Disease Control of the United States Public Health Service;

(b) “Confidential HIV-related information” means any information pertaining to the protected individual or obtained pursuant to a release of confidential HIV related information, concerning whether a person has been counseled regarding HIV infection, has been the subject of an HIV-related test, or has HIV infection, HIV-related illness or AIDS, or information which identifies or reasonably could identify a person as having one or more of such conditions, including information pertaining to such individual’s partners;

(c) “Exposure evaluation group” means at least three impartial health care providers, at least one of whom shall be a physician, designated by the chief administrator of a health facility, correctional facility or other institution to determine if a health care or other worker has been involved in a significant exposure. No member of the group shall be directly involved in the exposure;

(d) “FDA” means the United States Food and Drug Administration;

(e) “Health care provider” means any physician, dentist, nurse, provider of services for the mentally ill or persons with mental retardation, or other person involved in providing medical, nursing, counseling, or other health care, substance abuse or mental health service, including such services associated with, or under contract to, a health maintenance organization or medical services plan;

(f) “Health facility” means an institution, as defined in section 19a-490 of the general statutes, blood bank, blood center, sperm bank, organ or tissue bank, clinical laboratory or facility providing care or treatment to the mentally ill or persons with mental retardation or a facility for the treatment of substance abuse;

(g) “HIV infection” means infection with the human immunodeficiency virus or any other related virus identified as a probable causative agent of AIDS;

(h) “HIV-related illness” means any illness that may result from or may be associated with HIV infection;

(i) “HIV-related test” means any laboratory test or series of tests for any virus, antibody, antigen or etiologic agent whatsoever thought to cause or indicate the presence of HIV infection;

(j) “Meaningful immediate action” means any one of:

(1) the following actions related to drug therapy/prophylaxis—

(A) to start taking a drug that has been FDA approved for treatment of HIV related illness or has been approved for investigational use in humans for treatment of HIV-related illness, or to stop taking such drug if the source of the exposure tests negative for HIV, provided the drug:

(i) may prevent seroconversion in persons who have been exposed to HIV, or

(ii) may limit or ameliorate the effects of HIV infection,

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(B) to enroll in an experimental trial to determine whether a certain drug is effective in lessening the risk of HIV infection when administered after a significant exposure; or

(2) the following actions related to pregnancy/breast-feeding—

(A) a woman's decision whether to continue with or terminate a pregnancy where information concerning the HIV status of the person who was the source of the exposure may affect this decision,

(B) a woman's decision regarding planning pregnancy, where delay of pregnancy for a period of 6 months to 1 year may have adverse consequences due to age or other medical factors or if the worker or the worker's partner has had difficulty conceiving, where information concerning the HIV status of the person who was the source of the exposure may affect this decision,

(C) a breast-feeding woman's decision concerning continuation of breast-feeding, where information concerning the HIV status of the person who was the source of the exposure may affect this decision; or

(3) the following other actions—actions which could be taken before the worker would be able to know whether he/she was infected as a result of the exposure, provided that such action must either:

(A) be medically beneficial or potentially medically beneficial to the exposed person or to another person, or

(B) prevent potential HIV transmission that could not be prevented by any other means;

(k) "Partner" means an identified spouse or sex partner of the protected individual or a person identified as having shared hypodermic needles or syringes with the protected individual;

(l) "Protected individual" means a person who has been counseled regarding HIV infection, or is the subject of an HIV-related test or who has been diagnosed as having HIV infection, AIDS or HIV-related illness;

(m) "Release of confidential HIV-related information" means a written authorization for disclosure of confidential HIV-related information which is signed by the protected individual or a person authorized to consent to health care for the individual and which is dated and specifies to whom disclosure is authorized, the purpose for such disclosure and the time period during which the release is to be effective. A general authorization for the release of medical or other information is not a release of confidential HIV-related information, unless such authorization specifically indicates its dual purpose as a general authorization and an authorization for the release of confidential HIV-related information and complies with the requirements of this subsection;

(n) "Seroconversion" means the development of antibodies in response to HIV infection;

(o) "Significant exposure," means an exposure as defined in Section 19a-581 (14) of the general statutes and:

(1) contact between the mucous membranes (e.g. mouth or eyes) and at least one of the following: blood, a body fluid containing visible amounts of blood, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid;

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(2) contact through the skin (such as contact through an open wound or cut or by means of a needlestick or puncture wound injury) with at least one of the following: blood, a body fluid containing visible amounts of blood, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid;

(3) contact of skin, especially when the exposed skin is chapped, abraded or afflicted with dermatitis or the contact is prolonged or involving an extensive area, with at least one of the following: blood, a body fluid containing visible amounts of blood, cerebrospinal fluid, synovial fluid, pleural fluid, peritoneal fluid, pericardial fluid, amniotic fluid;

(4) sexual assault (involving anal, vaginal or oral intercourse) on a worker in the course of his or her occupational duties;

(p) “Significant exposure” does not include:

(1) exposure to urine, feces, sputum, nasal secretions, saliva, sweat, tears, or vomitus, unless the fluid in question contains visible amounts of blood;

(2) human bites or scratches, unless there is direct blood to blood or blood to mucous membrane contact;

(3) any exposure that would otherwise constitute a significant exposure, if the person exposed already has HIV infection.

(Effective April 2, 1991)

Sec. 19a-589-2. Testing and disclosure without consent

HIV related testing without the consent of the test subject, or disclosure of confidential HIV-related information without obtaining a release from the protected individual, is permitted in cases where a health care provider or other person in the course of his or her occupational duties has had a significant exposure, provided that all of the criteria set forth in section 19a-582 (e) (5) (A) through (e) (5) (I) or section 19a-583 (a) (7) (A) through (7) (F) of the general statutes are met.

(Effective April 2, 1991)

Sec. 19a-589-3. Records maintained for occupational exposures

(a) A health facility, correctional facility, other institution, or physician shall maintain records concerning each review of a request for testing or disclosure made pursuant to these regulations. Such records shall include sufficient documentation to establish whether the criteria for the occupational exposure exception specified in section 19a-582 (e) (5) (A) through (e) (5) (I) or section 19a-583 (a) (7) (A) through (a) (7) (F) of the general statutes and the requirements of these regulations have been satisfied, including (where appropriate):

(1) an incident report completed by the worker within forty-eight (48) hours of the exposure identifying the parties to the exposure, witnesses, time, place and nature of the event;

(2) documentation that the worker obtained a baseline HIV test within seventy-two (72) hours of the exposure and was negative on such test;

(3) a statement that the person who was the source of the exposure refused to consent to

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testing or disclosure, or is deceased;

(4) a statement of the exposure evaluation group's or physician's reasons for determining that a significant exposure has occurred and;

(5) a statement that if results are known the worker would be able to take meaningful immediate action as defined in subsection 19a-589-1 (j) of these regulations which could not otherwise be taken.

(b) These records shall be maintained separately from the person's medical record or any other records maintained by the health facility, correctional facility, other institution, or physician concerning that person.

(1) Such records shall be securely maintained.

(2) Access to these records shall be limited to the physician or to persons designated by the director or chief administrator of the health facility, correctional facility, other institution, or physician.

(3) Such records shall be maintained for a length of time in accordance with federal and state law.

(c) The laboratory performing the HIV-related test shall maintain records of any test result obtained pursuant to these regulations to the extent required by federal and/or state law.

(d) When the person's physician obtains voluntary consent to testing after an occupational exposure, or when involuntary testing is authorized, as provided in section 19a-581 (e) (5) (D) of the general statutes, no record of the existence or results of the HIV-related test will appear in the person's medical or other records unless the test result is relevant to the medical care the person is receiving at that time, or the person makes a specific written request that the test result be recorded.

(1) If the person consents to testing, they shall be told during the informed consent discussion that the test result may be recorded in their medical record if it is relevant to the medical care they are receiving at that time or if they make a specific written request that the result be recorded.

(2) If the person has refused to consent to testing but involuntary testing as provided in section 19a-582 (e) (5) of the general statutes is authorized, at the time the person is offered their test result and provided with counseling as required by subsections (d) and (e) (5) (H) of said section, the person shall be informed that their test result may be recorded in their medical record if it is relevant to the medical care they are receiving at that time or if they make a specific written request that the test result be recorded.

(3) If the result is recorded because it is relevant to the medical care the person is receiving at that time, the physician's reasons for determining that the test result is relevant shall be documented.

(4) Test results shall not be recorded in a person's medical record for the purpose of enabling health care providers or other persons to avoid contact with, or take special precautions when coming into contact with that person.

(Effective April 2, 1991)

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Office of Healthcare Access Division

Sec. 19a-613-1. Description

The Office of Health Care Access (OHCA) division of the Department of Public Health derives its authority primarily from Chapter 368z of the Connecticut General Statutes. The powers of the Office are vested in and exercised by a deputy commissioner of Public Health, appointed as provided in section 19a-612d of the Connecticut General Statutes.

(Effective April 9, 2013)

Sec. 19a-613-2. Function

The Office of Health Care Access is generally empowered to exercise specified grants of authority over the establishment and operation of health care facilities as defined in section 19a-630 of the Connecticut General Statutes. The Office is responsible for preparing the Statewide Health Care Facilities and Services Plan, administering the certificate of need process and collecting inpatient discharge data and financial data from hospitals.

(Effective April 9, 2013)

Sec. 19a-613-3. Official address and hours

The principal office of the Office of Health Care Access is located at and all communications should be addressed to the Office of Health Care Access, 410 Capitol Avenue, MS#13HCA, P. O. Box 340308, Hartford, CT 06134-0308. The office is open from 8:30 a.m. to 4:30 p.m. Monday through Friday except legal holidays.

(Effective April 9, 2013)

Sec. 19a-613-4. Public information

The public may inspect the regulations, decisions and all public records of the Office of Health Care Access at its office. Written requests for public information shall be filed on the Freedom of Information request forms available on the Office's website.

(Effective April 9, 2013)

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**Definitions Applicable to Sections 19a-630-1 through 19a-653-4, Inclusive, of the
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Definitions Applicable to Sections 19a-630-1 through 19a-653-4, Inclusive, of the Regulations of Connecticut State Agencies

Sec. 19a-630-1. Certificate of need

Definitions. As used in sections 19a-630-1 to 19a-653-4, inclusive, of the Regulations of Connecticut State Agencies:

(1) “Acquisition” means the acquisition through purchase, lease, donation or other comparable arrangement of a computed tomography scanner, magnetic resonance imaging scanner, positron emission tomography scanner, positron emission tomography-computed tomography scanner, linear accelerator or equipment that utilizes technology that has not previously been utilized in the state;

(2) “Central Service Facility” means a health care facility or institution, person or entity engaged primarily in providing services for the prevention, diagnosis or treatment of human health conditions, serving one or more health care facilities, practitioners or institutions and satisfying the criteria for a central service facility as discussed in section 19a-630-2 of the Regulations of Connecticut State Agencies;

(3) “Day”, unless specified otherwise in statute or regulation, means a calendar day;

(4) “Freestanding Emergency Department” means an emergency department that is not located on the main campus of a hospital and is held out to the public (by name, posted signs, advertising or other means) as a place that provides care for emergency medical conditions on an urgent basis without requiring a previously scheduled appointment;

(5) “Interventional cardiology” means non-surgical procedures used in the treatment of coronary artery and peripheral vascular disease and performed in the cardiac catheterization laboratory. Procedures include, but are not limited to, angioplasty, valvuloplasty, cardiac ablation, coronary thrombectomy, and congenital heart defect correction;

(6) “Office” or “OHCA” means the Office of Health Care Access division of the Department of Public Health, as established by section 19a-612 of the Connecticut General Statutes;

(7) “Provider” means any person or entity that provides health care services;

(8) “Psychiatric residential treatment facility” means a psychiatric residential treatment facility as defined in 42 CFR 483.352.

(Effective April 9, 2013)

Sec. 19a-630-2. Criteria for determining if an entity is a central service facility

(a) An entity shall be a central service facility if it meets one or more of the following criteria:

(1) The entity is institutional in nature and practice;

(2) Patient care is or may be the responsibility of the entity rather than of the individual physicians or practitioners;

(3) Nonmedical personnel, owners or managers can or may be able to influence the operation of the entity to a significant degree;

(4) With the exception of practicing physician groups, the entity that is or may be

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providing services for the prevention, diagnosis or treatment of human health conditions to two or more providers;

(5) The owner, partner or manager of an entity as described in subdivision (4) of this subsection is a physician who is not practicing medicine at the entity; or

(6) A partnership with general and managing partners exists.

(b) In determining whether a particular entity meets any of the criteria in subsection (a) of this section, the commissioner, commissioner's designee or deputy commissioner may consider the following:

(1) Whether the entity is or may be licensed or designated as any type of health care facility or institution by the department;

(2) Whether the patients have any prior familiarity with the physician or practitioner or any ongoing relationship with the physician or practitioner;

(3) Whether services such as laboratory, pharmacy, x-ray, linear accelerator and imaging, are or may be available with no free choice of the provider of such services by the patient;

(4) Whether the entity can continue to function even if the license of its physician or physicians has, have been or may be suspended or revoked, since the entity can simply retain another physician or practitioner;

(5) Whether bills and charges are or may be determined by the entity rather than the individual physicians or practitioners who provide the care or the service;

(6) Whether income distribution is or may be determined by the entity rather than entirely by the individual physicians or practitioners who provide the care of service;

(7) Whether there are present interlocking relationships, corporate relationships or entities with other health related corporate relationships, entities or properties;

(8) Whether the location and services provided are a small part of a larger entity; and

(9) Any other information the commissioner, commissioner's designee or deputy commissioner deems relevant or pertinent.

(Effective April 9, 2013)

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Certificate of Need Determination Request; Policies Concerning Outpatient Operating Room Increases, Cardiac Services and Imaging Equipment Replacement

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Certificate of Need Determination Request; Policies Concerning Outpatient Operating Room Increases, Cardiac Services and Imaging Equipment Replacement

Sec. 19a-638-1. Increase in operating rooms

Any outpatient surgical facility that increases the number of its operating rooms on and after October 1, 2010, shall file a notification with the Office indicating the date on which the operating rooms were added, the number of its operating rooms added and the total number of operating rooms including the new operating room or operating rooms.

(Effective April 9, 2013)

Sec. 19a-638-2. Establishment of cardiac services

Interventional cardiology procedures that are authorized pursuant to a certificate of need may be performed by a health care facility or provider and several procedures may be authorized under one certificate of need. A facility that is authorized to provide open heart surgery is authorized to provide all of the interventional cardiology procedures listed in section 19a-630-1(5) of the Regulations of Connecticut State Agencies.

(Effective April 9, 2013)

Sec. 19a-638-3. Replacement of imaging equipment

Any health care facility, person or provider that replaces equipment shall notify the Office of the date on which the equipment was replaced and the disposition of the replaced equipment pursuant to section 19a-638 of the Connecticut General Statutes. The notification shall also include the docket number of the certificate of need or certificate of need determination. The Office shall place the notification in the original file for the corresponding docket number.

(Effective April 9, 2013)

Sec. 19a-638-4. Determinations

All requests for determinations as to whether a certificate of need is required shall be submitted to the Office on a Determination Form, which is available on the Office's website. The Office shall not review a request for determination until a complete form has been submitted and all required information has been provided to the Office. Requests for determination may be submitted electronically in PDF format or via facsimile.

(Effective April 9, 2013)

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Certificate of Need Application Process

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Certificate of Need Application Process

Sec. 19a-639a-1. Public notification of certificate of need application

Pursuant to section 19a-639a of the Connecticut General Statutes, not later than twenty days prior to the submission of a certificate of need application, the applicant shall publish notice that an application is to be submitted in a newspaper having substantial circulation in the area where the project is to be located. An applicant shall file the application not later than ninety days after publishing notice. The notice shall contain the following information:

- (1) A statement that the applicant is applying for a certificate of need pursuant to section 19a-638 of the Connecticut General Statutes;
- (2) A description of the scope and nature of the project;
- (3) The street address where the project is to be located; and
- (4) The total capital expenditure for the project.

(Effective April 9, 2013)

Sec. 19a-639a-2. Newspapers with substantial circulation in town where project is to be located

A list of towns in Connecticut and the corresponding newspapers of substantial circulation in each town are available on the Office's website. The Office will update the list as necessary.

(Effective April 9, 2013)

Sec. 19a-639a-3. Certificate of need application

(a) The application shall consist of the following:

(1) The appropriate application form which should be filled out in its entirety and all supporting documents should be attached to the application and referenced as either an attachment or exhibit in the order in which they appear in the application for the specific type of proposal, as follows, which are available and may be downloaded from the Office's website:

(A) Establishment of a new health care facility as defined in section 19a-630 of the Connecticut General Statutes;

(B) Establishment of an outpatient surgical facility;

(C) Establishment of a freestanding emergency department;

(D) Transfer of ownership of a health care facility;

(E) Termination of inpatient or outpatient services by a short-term acute care general hospital or children's hospital;

(F) Termination of surgical services by an outpatient surgical facility or a facility that provides outpatient surgical services as part of the outpatient surgery department of a hospital pursuant to section 19a-638 of the Connecticut General Statutes;

(G) Termination of an emergency department by a short-term acute care general hospital;

(H) Establishment of cardiac services;

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(I) Acquisition of any of the equipment enumerated in section 19a-638 of the Connecticut General Statutes;

(J) Increase in licensed bed capacity; and

(K) Increase in operating rooms by an outpatient surgical facility pursuant to section 19a-638 of the Connecticut General Statutes.

(2) A copy of the notice of the certificate of need application demonstrating that such notice was published for at least three consecutive days in a newspaper having substantial circulation in the town in which the project is going to be located pursuant to section 19a-639a of the Connecticut General Statutes;

(3) A description of the project setting forth the proposal in as much detail as possible. The description shall reference the applicable requirement for a certificate of need under section 19a-638 of the Connecticut General Statutes;

(4) The specific location of the facility, service or equipment;

(5) A detailed description of how the proposal relates to each of the guidelines and principles enumerated in section 19a-639 of the Connecticut General Statutes and any supporting documentation; and

(6) All other information as required by the specific application form, which is available on the Office's website.

(b) One original and four copies of the application shall be submitted to the Office at 410 Capitol Avenue, MS#13HCA, Hartford, CT 06134. The application shall be accompanied by the five hundred dollar filing fee pursuant to section 19a-639a of the Connecticut General Statutes. If the application including attachments or exhibits does not exceed fifty pages, it may be filed electronically in accordance with subsection (c) of this section.

(c) Applications not exceeding fifty pages may be filed electronically in PDF format. All applications exceeding fifty pages must be filed in accordance with subsection (b) of this section.

(d) Applications shall be deemed received on the date and time at which the Office receives the document or the complete electronic version of the document. Any documents received after normal business hours shall be deemed received on the following business day.

(Effective April 9, 2013)

Sec. 19a-639a-4. Certificate of need - completeness review

(a) Pursuant to section 19a-639a of the Connecticut General Statutes, the Office shall have thirty days to review the application and request additional information as necessary to complete the application. The applicant shall have sixty days from the date of the request to provide responses to the request for additional information and said responses may be filed electronically in PDF format or via facsimile. If the applicant fails to respond within the sixty day time frame, the application shall be deemed withdrawn in accordance with section 19a-639a of the Connecticut General Statutes.

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(b) Upon receipt of the responses, the Office shall have thirty days to review the responses and make a determination with respect to whether the application is complete or if further information is needed. If additional information is sought, the applicant shall have another sixty days to respond. If the applicant fails to respond within the sixty day time frame, the application shall be deemed withdrawn in accordance with section 19a-639a of the Connecticut General Statutes.

(c) The review cycle described above shall continue until the Office deems an application complete.

(Effective April 9, 2013)

Sec. 19a-639a-5. Certificate of need review period

(a) Pursuant to section 19a-639a of the Connecticut General Statutes, the ninety day review period for a completed application shall begin on the date the Office posts notice of the completed application on its website. No later than seven days after the thirty day review period for completeness has expired, the Office shall post notice of the completed application on its website. The Office shall also provide notice to the applicant that its application is complete via first class mail, facsimile or electronic mail and this notice shall include the date on which the ninety day review period expires. The posting on the Office website shall serve as notice to any interested members of the public.

(b) Extensions of the Review Period

(1) The Office may extend the review period for good cause for a total of sixty days in accordance with section 19a-639a of the Connecticut General Statutes. If the Office extends the review period, the Office shall provide notice to the applicant that review has been extended via first class mail, facsimile or electronic mail and this notice shall include the date on which the review period expires.

(2) Where a public hearing is held pursuant to section 19a-639a of the Connecticut General Statutes, the review period shall be extended for another sixty days after the date on which the public hearing record is closed. The Office shall notify the applicant of the date on which the public hearing record is closed via first class mail, facsimile or electronic mail and this notice shall include the date on which the review period expires.

(Effective April 9, 2013)

Sec. 19a-639a-6. Notice of public hearing

The Office shall provide notice of the date, time and place of the public hearing in a newspaper having substantial circulation in the town in which the project is to be located not less than two weeks prior to the date of the hearing pursuant to section 19a-639a of the Connecticut General Statutes. The Office shall also provide a copy of the notice via first class mail, facsimile or electronic mail to the applicant and any individuals or entities that have requested a hearing pursuant to section 19a-639a of the Connecticut General Statutes. Additionally, the Office shall post the notice of public hearing on its website.

(Effective April 9, 2013)

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Sec. 19a-639b-2.	Non- transferability of the certificate of need

Certificate of Need Expiration, Extension and Non-Transferability

Sec. 19a-639b-1. Expiration and extension of certificate of need

(a) A certificate of need shall expire two years from the date of issuance by the Office unless the applicant has requested an extension of the certificate of need at least thirty days in advance of the expiration of the certificate of need pursuant to section 19a-639b of the Connecticut General Statutes.

(b) At a minimum, a request for an extension of a certificate of need shall contain the following:

(1) A detailed description of any change in the cost, configuration, services or scope of the project;

(2) A detailed description and documentation of any progress on the project including preparation of construction drawings, securing of necessary funds and building permits and commencement of any construction;

(3) An estimated timetable for commencement and completion of all remaining components of the project; and

(4) Documentation of an extenuating circumstance, including, but not limited to, delays occasioned by negotiations with vendors or contractors, beyond the control of the applicant that prevented the applicant from completing the project by the expiration date.

(c) The following criteria shall be used to determine whether an extension will be granted to the applicant:

(1) Site procurement: The applicant shall have made progress toward permanent acquisition of the intended site for the project.

(2) Financial status: The applicant shall be able to provide documentation regarding finalizing any necessary loans or lease purchase arrangements.

(3) The applicant shall provide reasonable assurance that the project will be under construction or implemented within the requested extension time frame.

(Effective April 9, 2013)

Sec. 19a-639b-2. Non-transferability of the certificate of need

A certificate of need is non-transferable. A certificate of need or rights thereunder may not be sold, assigned, leased, transferred, mortgaged, or pledged. Any attempt to transfer a certificate of need shall result in the immediate voiding of the certificate of need.

(Effective April 9, 2013)

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Healthcare Facility Relocation; Certificate of Need

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Sec. 19a-639c-1.	Relocation of a health care facility
Sec. 19a-639c-2.	Certificate of need for relocation

Healthcare Facility Relocation; Certificate of Need

Sec. 19a-639c-1. Relocation of a health care facility

(a) Pursuant to section 19a-639c of the Connecticut General Statutes, any health care facility that proposes to relocate its facility, shall submit a letter requesting that the Office make a determination as to whether a certificate of need is required. A form for the relocation of a health care facility, which shall be submitted with such letter, is available on the Office's website.

(b) Based upon the information submitted by the applicant, the Office shall determine whether there has been substantial change in the payer mix or the population served by the health care facility that proposes to relocate. The applicant shall provide the percentages of total patient volume by payer source prior to the relocation and following the relocation.

(Effective April 9, 2013)

Sec. 19a-639c-2. Certificate of need for relocation

Any health care facility that proposes to relocate its facility and is unable to demonstrate to the satisfaction of the Office that the relocation will not result in a substantial change in the payer mix or population served shall file a certificate of need for the establishment of a new health care facility pursuant to section 19a-638 of the Connecticut General Statutes.

(Effective April 9, 2013)

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Termination of Healthcare Facility or Services; Certificate of Need

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Sec. 19a-639e-1.	Termination of a health care facility
Sec. 19a-639e-2.	Termination of services provided by a health care facility

Termination of Healthcare Facility or Services; Certificate of Need

Sec. 19a-639e-1. Termination of a health care facility

(a) Any health care facility that was authorized through a certificate of need shall provide notice that it is terminating services not later than sixty days prior to the termination. The notification shall contain the following:

- (1) The name and location of the health care facility;
- (2) Reason for closing the facility;
- (3) Other facilities where patients may be able to obtain the services that are currently provided by the facility that intends to close; and
- (4) Date on which the facility will be closed.

(b) Any health care facility that was not authorized through a certificate of need and intends to close the facility shall notify the Office not later than sixty days prior to the termination of the facility. The notification shall contain the following:

- (1) The name and location of the health care facility;
- (2) Reason for closing the facility that intends to close;
- (3) Other facilities where patients may obtain the services that are currently provided by the facility that intends to close; and
- (4) Date on which the services will no longer be provided or on which the facility will be closed.

(Effective April 9, 2013)

Sec. 19a-639e-2. Termination of services provided by a health care facility

(a) Unless otherwise required to file a certificate of need application pursuant to the provisions of section 19a-638 of the Connecticut General Statutes, any health care facility that intends to terminate a service or services which were authorized pursuant to a certificate of need shall file a modification of the original certificate of need on the forms available on the Office's website. The applicant shall provide the following information to the Office:

- (1) The service or services that the facility will no longer provide;
- (2) The reasons that the facility will no longer provide the service or services;
- (3) Other facilities where the patients may obtain the service or services which the facility will no longer provide; and
- (4) The date on which the service or services will be terminated.

(b) Any health care facility that intends to terminate a service or services which were not authorized pursuant to a certificate of need shall notify the Office not later than sixty days prior to the termination of the service or services. The notification shall contain the following:

- (1) The service or services that the facility will no longer provide;
- (2) The reason that the facility will no longer provide the service or services;
- (3) Other facilities where the patients may obtain the service or services which the facility will no longer provide; and

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(4) The date on which the service or services will be terminated.

(Effective April 9, 2013)

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Sec. 19a-643-2.	Functions (Repealed)
Sec. 19a-643-3.	Official address and hours (Repealed)
Sec. 19a-643-4.	Public information (Repealed)
Sec. 19a-643-5—19a-643-7.	Reserved (Repealed)

RULES OF PRACTICE

ARTICLE 1: GENERAL PROVISIONS

Part 1: Scope and Construction of Rules

Sec. 19a-643-8.	Procedure governed (Repealed)
Sec. 19a-643-9.	Attorney defined (Repealed)
Sec. 19a-643-10.	Definitions I (Repealed)
Sec. 19a-643-11.	Definitions II (Repealed)
Sec. 19a-643-12.	Criteria for determining if an entity is a “central service facility” (Repealed)
Sec. 19a-643-13—19a-643-15.	Reserved (Repealed)
Sec. 19a-643-16.	Waiver of rules (Repealed)
Sec. 19a-643-17.	Construction and amendment (Repealed)
Sec. 19a-643-18.	Computation of time (Repealed)
Sec. 19a-643-19.	Extensions of time (Repealed)
Sec. 19a-643-20.	Effect of filing (Repealed)
Sec. 19a-643-21.	Consolidation of proceedings (Repealed)
Sec. 19a-643-22.	Forms (Repealed)
Sec. 19a-643-23.	Ex parte communications (Repealed)
Sec. 19a-643-24.	Declaratory rulings (Repealed)
Sec. 19a-643-25.	Civil penalty for failure to file data (Repealed)
Sec. 19a-643-26—19a-643-28.	Reserved (Repealed)

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TITLE 19a. Public Health and Well-Being

Part 2: Formal Requirements

Sec. 19a-643-29.	Filing of documents (Repealed)
Sec. 19a-643-30.	Identification of communications (Repealed)
Sec. 19a-643-31.	Signatures (Repealed)
Sec. 19a-643-32.	Formal requirements as to documents and other papers filed in proceedings (Repealed)
Sec. 19a-643-33.	Service (Repealed)
Sec. 19a-643-34—19a-643-35.	Reserved (Repealed)

ARTICLE 2: CONTESTED CASES

Part 1: Parties, Intervention and Participation

Sec. 19a-643-36.	Designation of parties (Repealed)
Sec. 19a-643-37.	Application to be designated a party (Repealed)
Sec. 19a-643-38.	Participation by intervenors (Repealed)
Sec. 19a-643-39.	Participation by informal participants (Repealed)
Sec. 19a-643-40.	Procedure concerning added parties (Repealed)
Sec. 19a-643-41.	Representation of parties and intervenors (Repealed)
Sec. 19a-643-42—19a-643-43.	Reserved (Repealed)

Part 2: Hearing, General Provisions

Sec. 19a-643-44.	Commencement of contested case (Repealed)
Sec. 19a-643-45.	Waiver of hearing (Repealed)
Sec. 19a-643-46.	Calendar of hearings (Repealed)
Sec. 19a-643-47.	Place of hearings (Repealed)
Sec. 19a-643-48.	Notice of hearings (Repealed)
Sec. 19a-643-49—19a-643-50.	Reserved (Repealed)

Part 3: Hearings, Procedure

Sec. 19a-643-51.	General provisions (Repealed)
Sec. 19a-643-52.	Witnesses, subpoenas, and production of records (Repealed)
Sec. 19a-643-53.	Rules of evidence (Repealed)
Sec. 19a-643-54.	Filing of added exhibits and testimony (Repealed)
Sec. 19a-643-55.	Requests for production (Repealed)
Sec. 19a-643-56.	Responses to requests for production — objections (Repealed)
Sec. 19a-643-57.	Motions for compliance (Repealed)
Sec. 19a-643-58.	Rulings on motions for compliance (Repealed)

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TITLE 19a. Public Health and Well-Being

- Sec. 19a-643-59. Failure to comply with an order on a motion for compliance (Repealed)
- Sec. 19a-643-60. Continuing duty to disclose (Repealed)
- Sec. 19a-643-61. Subpoenas issued pursuant to section 51-85 of the Connecticut General Statutes (Repealed)
- Sec. 19a-643-62—19a-643-63. Reserved (Repealed)

Part 4: Hearings, Decision

- Sec. 19a-643-64. Uncontested disposition of case (Repealed)
- Sec. 19a-643-65. Proposed final decision (Repealed)
- Sec. 19a-643-66. Final decision (Repealed)
- Sec. 19a-643-67—19a-643-68. Reserved (Repealed)

ARTICLE 3: PETITIONS AND APPLICATIONS

Part 1: Petitions and Applications, General Provisions

- Sec. 19a-643-69. General rule (Repealed)
- Sec. 19a-643-70. Function of application (Repealed)
- Sec. 19a-643-71. Required components, general (Repealed)
- Sec. 19a-643-72. Original records (Repealed)
- Sec. 19a-643-73. Fees (Repealed)
- Sec. 19a-643-74. Date of filing, components, deficiencies (Repealed)
- Sec. 19a-643-75. Notification of the status of reviews, monthly status reports (Repealed)
- Sec. 19a-643-76—19a-643-77. Reserved (Repealed)

Part 2: Review of Capital Expenditure, Additional Function or Additional Service Proposals

- Sec. 19a-643-78. General rule (Repealed)
- Sec. 19a-643-79. Letters of intent (Repealed)
- Sec. 19a-643-80. Applications (Repealed)
- Sec. 19a-643-81. Expedited review application submissions (Repealed)
- Sec. 19a-643-82. Certificate of need (CON) filing fees (Repealed)
- Sec. 19a-643-83. Special components for applications under sections 19a-638 and 19a-639 of the Connecticut General Statutes (Repealed)
- Sec. 19a-643-84. Criteria of review (Repealed)
- Sec. 19a-643-85. Proposed introduction into health care program of an additional function or service, termination of service or substantial reduction in bed capacity (Repealed)

Regulations of Connecticut State Agencies

TITLE 19a. Public Health and Well-Being

- Sec. 19a-643-86. pealed)
Proposed capital expenditure or equipment acquisition (Repealed)
- Sec. 19a-643-87. Initial budget, initial rates and charges, general (Repealed)
- Sec. 19a-643-88—19a-643-89. Reserved (Repealed)

Part 3: Exemption or Waiver of Certificate of Need Review

- Sec. 19a-643-90. Waiver of certificate of need review for year-2000 computer capability (Repealed)
- Sec. 19a-643-91. Exemption from certificate of need review (Repealed)
- Sec. 19a-643-92. Waiver of certificate of need review under section 5 of Public Act 98-150 (Repealed)
- Sec. 19a-643-93. Reserved (Repealed)

Part 4: Establishment of an Expedited Hearing Process for the Review of Certain Capital Expenditures

- Sec. 19a-643-94. General rule (Repealed)
- Sec. 19a-643-95. Definitions III (Repealed)
- Sec. 19a-643-96. Procedures for review (Repealed)
- Sec. 19a-643-97. Other provisions (Repealed)
- Sec. 19a-643-98. Reserved (Repealed)
- Sec. 19a-643-99. Disclosure required under Chapter 368z of the Connecticut General Statutes (Repealed)
- Sec. 19a-643-100—19a-643-101. Reserved (Repealed)

Part 5: Rate Regulation and Budget Review

- Sec. 19a-643-102. General rule (Repealed)
- Sec. 19a-643-103. Special components for rate applications (Repealed)
- Sec. 19a-643-104. Offers of proof (Repealed)
- Sec. 19a-643-105. Applicable criteria (Repealed)
- Sec. 19a-643-106. Authorization of budgets and schedules of rates and charges (Repealed)
- Sec. 19a-643-107. Increases in rates or charges under authority of section 19a-635 of the Connecticut General Statutes (Repealed)
- Sec. 19a-643-108. Increases in rates or charges under authority of section 19a-636 of the Connecticut General Statutes (Repealed)

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TITLE 19a. Public Health and Well-Being

Sec. 19a-643-109.	Proposed operating and capital expenditures budget (Repealed)
Sec. 19a-643-110.	Ongoing inspection of budgets (Repealed)
Sec. 19a-643-111—19a-643-199.	Reserved

Hospital Financial Review

Sec. 19a-643-200.	General purpose
Sec. 19a-643-201.	Definitions
Sec. 19a-643-202.	Consistency
Sec. 19a-643-203.	Pricemaster
Sec. 19a-643-204.	Filing of pricemaster data
Sec. 19a-643-205.	Hospital budget filing (Repealed)
Sec. 19a-643-206.	Annual reporting and twelve months actual filing

Office of Healthcare Access Rules of Practice

Sec. 19a-643-207.	Rules of practice
Sec. 19a-643-208.	Consolidation of proceedings

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TITLE 19a. Public Health and Well-Being

Department of Public Health

§19a-643-10

Administrative Regulations and Rules of Practice Description of Organization

(See § 19a-160)

Sec. 19a-643-1. Description (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-2. Functions (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-3. Official address and hours (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-4. Public information (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-5—19a-643-7. Reserved (Repealed)

Repealed April 9, 2013.

RULES OF PRACTICE

ARTICLE 1: GENERAL PROVISIONS

Part 1: Scope and Construction of Rules

Sec. 19a-643-8. Procedure governed (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-9. Attorney defined (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-10. Definitions I (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

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§19a-643-11

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Sec. 19a-643-11. Definitions II (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-12. Criteria for determining if an entity is a “central service facility” (Repealed)

Repealed April 9, 2013.

(Adopted effective February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-13—19a-643-15. Reserved (Repealed)

Repealed April 9, 2013.

Sec. 19a-643-16. Waiver of rules (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-17. Construction and amendment (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-18. Computation of time (Repealed)

Repealed April 9, 2013.

(Effective December 17, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-19. Extensions of time (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-20. Effect of filing (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-21. Consolidation of proceedings (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

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§19a-643-32

Sec. 19a-643-22. Forms (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-23. Ex parte communications (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-24. Declaratory rulings (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-25. Civil penalty for failure to file data (Repealed)

Repealed April 9, 2013.

(Effective February 23, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-26—19a-643-28. Reserved (Repealed)

Repealed April 9, 2013.

Part 2: Formal Requirements

Sec. 19a-643-29. Filing of documents (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-30. Identification of communications (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-31. Signatures (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-32. Formal requirements as to documents and other papers filed in proceedings (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

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TITLE 19a. Public Health and Well-Being

§19a-643-33

Department of Public Health

Sec. 19a-643-33. Service (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-34—19a-643-35. Reserved (Repealed)

Repealed April 9, 2013.

ARTICLE 2: CONTESTED CASES

Part 1: Parties, Intervention and Participation

Sec. 19a-643-36. Designation of parties (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-37. Application to be designated a party (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-38. Participation by intervenors (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-39. Participation by informal participants (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-40. Procedure concerning added parties (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-41. Representation of parties and intervenors (Repealed)

Repealed April 9, 2013.

(Effective December 17, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-42—19a-643-43. Reserved (Repealed)

Repealed April 9, 2013.

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TITLE 19a. Public Health and Well-Being

Department of Public Health

§19a-643-52

Part 2: Hearing, General Provisions

Sec. 19a-643-44. Commencement of contested case (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-45. Waiver of hearing (Repealed)

Repealed April 9, 2013.

(Effective December 17, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-46. Calendar of hearings (Repealed)

Repealed April 9, 2013.

(Effective December 17, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-47. Place of hearings (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-48. Notice of hearings (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-49—19a-643-50. Reserved (Repealed)

Repealed April 9, 2013.

Part 3: Hearings, Procedure

Sec. 19a-643-51. General provisions (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-52. Witnesses, subpoenas, and production of records (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

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TITLE 19a. Public Health and Well-Being

§19a-643-53

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Sec. 19a-643-53. Rules of evidence (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-54. Filing of added exhibits and testimony (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-55. Requests for production (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-56. Responses to requests for production — objections (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-57. Motions for compliance (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-58. Rulings on motions for compliance (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-59. Failure to comply with an order on a motion for compliance (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-60. Continuing duty to disclose (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-61. Subpoenas issued pursuant to section 51-85 of the Connecticut General Statutes (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

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TITLE 19a. Public Health and Well-Being

Department of Public Health

§19a-643-72

Sec. 19a-643-62—19a-643-63. Reserved (Repealed)

Repealed April 9, 2013.

Part 4: Hearings, Decision

Sec. 19a-643-64. Uncontested disposition of case (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-65. Proposed final decision (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-66. Final decision (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-67—19a-643-68. Reserved (Repealed)

Repealed April 9, 2013.

ARTICLE 3: PETITIONS AND APPLICATIONS

Part 1: Petitions and Applications, General Provisions

Sec. 19a-643-69. General rule (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-70. Function of application (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-71. Required components, general (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-72. Original records (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

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TITLE 19a. Public Health and Well-Being

§19a-643-73

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Sec. 19a-643-73. Fees (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-74. Date of filing, components, deficiencies (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-75. Notification of the status of reviews, monthly status reports (Repealed)

Repealed April 9, 2013.

(Effective December 17, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-76—19a-643-77. Reserved (Repealed)

Repealed April 9, 2013.

Part 2: Review of Capital Expenditure, Additional Function or Additional Service Proposals

Sec. 19a-643-78. General rule (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-79. Letters of intent (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-80. Applications (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-81. Expedited review application submissions (Repealed)

Repealed April 9, 2013.

(Effective December 22, 1992; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

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Department of Public Health

§19a-643-90

Sec. 19a-643-82. Certificate of need (CON) filing fees (Repealed)

Repealed April 9, 2013.

(Effective December 22, 1992; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-83. Special components for applications under sections 19a-638 and 19a-639 of the Connecticut General Statutes (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-84. Criteria of review (Repealed)

Repealed April 9, 2013.

(Effective December 17, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-85. Proposed introduction into health care program of an additional function or service, termination of service or substantial reduction in bed capacity (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-86. Proposed capital expenditure or equipment acquisition (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-87. Initial budget, initial rates and charges, general (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-88—19a-643-89. Reserved (Repealed)

Repealed April 9, 2013.

Part 3: Exemption or Waiver of Certificate of Need Review

Sec. 19a-643-90. Waiver of certificate of need review for year-2000 computer capability (Repealed)

Repealed April 9, 2013.

(Adopted effective February 26, 1999; Repealed April 9, 2013)

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TITLE 19a. Public Health and Well-Being

§19a-643-91

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Sec. 19a-643-91. Exemption from certificate of need review (Repealed)

Repealed April 9, 2013.

(Adopted effective February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-92. Waiver of certificate of need review under section 5 of Public Act 98-150 (Repealed)

Repealed April 9, 2013.

(Adopted effective February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-93. Reserved (Repealed)

Repealed April 9, 2013.

Part 4: Establishment of an Expedited Hearing Process for the Review of Certain Capital Expenditures

Sec. 19a-643-94. General rule (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-95. Definitions III (Repealed)

Repealed April 9, 2013.

(Effective December 17, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-96. Procedures for review (Repealed)

Repealed April 9, 2013.

(Effective December 22, 1992; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-97. Other provisions (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-98. Reserved (Repealed)

Repealed April 9, 2013.

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TITLE 19a. Public Health and Well-Being

Department of Public Health

§19a-643-107

Sec. 19a-643-99. Disclosure required under Chapter 368z of the Connecticut General Statutes (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-100—19a-643-101. Reserved (Repealed)

Repealed April 9, 2013.

Part 5: Rate Regulation and Budget Review

Sec. 19a-643-102. General rule (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-103. Special components for rate applications (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-104. Offers of proof (Repealed)

Repealed April 9, 2013.

(Effective August 23, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-105. Applicable criteria (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-106. Authorization of budgets and schedules of rates and charges (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-107. Increases in rates or charges under authority of section 19a-635 of the Connecticut General Statutes (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

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Sec. 19a-643-108. Increases in rates or charges under authority of section 19a-636 of the Connecticut General Statutes (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-109. Proposed operating and capital expenditures budget (Repealed)

Repealed April 9, 2013.

(Effective December 17, 1984; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-110. Ongoing inspection of budgets (Repealed)

Repealed April 9, 2013.

(Effective April 20, 1990; Transferred and Amended February 26, 1999; Repealed April 9, 2013)

Sec. 19a-643-111—19a-643-199. Reserved

Hospital Financial Review

Sec. 19a-643-200. General purpose

Each hospital subject to Chapter 368z, including, but not limited, to sections 19a-613, 19a-637a, 19a-643, 19a-644, 19a-649, 19a-673c, 19a-676 and 19a-681 of the Connecticut General Statutes, shall be required to submit certain financial information and statistical data annually to the Office of Health Care Access for its review.

Nothing in sections 19a-643-200 through 19a-643-206, inclusive, shall be interpreted as preventing the office from reviewing any financial or statistical reporting requirement in carrying out its mandate under Connecticut laws.

(Transferred from § 19a-167g-51, November 1, 2007; Amended November 1, 2007)

Sec. 19a-643-201. Definitions

(a) The definitions provided by section 19a-630, of the Connecticut General Statutes and sections 19a-643-10 and 19a-643-11 of the Regulations of Connecticut State Agencies, except as otherwise noted, shall govern the interpretation and application of sections 19a-643-200 to 19a-643-206, inclusive.

(b) The following definitions shall apply to the review by the office of all matters concerning hospital financial information or statistical data reporting requirements, as applicable:

(1) “Affiliate” means a person, entity or organization controlling, controlled by, or under common control with another person, entity or organization, including but not limited to parent corporations, holding companies, related entities, joint ventures and partnerships. Factors to be considered include: common ownership of fifty or more percent; shared boards of directors; purpose; and whether an entity operates for the benefit of others. Control exists

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where an individual or organization has the power, directly or indirectly, to direct the actions or policy of an organization or entity. A person, entity or organization may be an affiliate for purposes of a particular project;

(2) “Ambulatory payment classification” or “APC” means the system of classifying outpatient department (OPD) services reimbursed under the Medicare program prospective payment system for hospital outpatient services as set forth in 42 USC 1833 (t) as from time to time amended;

(3) “Bad debts” means the year-end adjustment to a hospital’s allowance for doubtful accounts due to the non-reimbursement of services rendered to patients from whom reimbursement was expected, resulting in the recording of bad debt expense. Bad debts exclude any financial activity not associated with patient accounts receivable;

(4) “Base year” means “base year” as defined in section 19a-659 of the Connecticut General Statutes;

(5) “Board-designated funds” means the unrestricted funds available for specific purposes or projects;

(6) “Budget year” means the twelve month fiscal period subsequent to the current year or base year beginning October 1st and ending the following September 30th. If John Dempsey Hospital of the University of Connecticut Health Center elects to operate and report on a state fiscal year basis, the budget year for that hospital shall be the twelve month period subsequent to the current year or base year beginning July 1st and ending the following June 30th;

(7) “By” means budget year;

(8) “Capital expenditures” means the expenditures for items which, at the time of acquisition have an estimated useful life of at least two years and a purchase price of at least \$5,000. In addition, capital expenditures shall include expenditures of at least \$10,000 for groups of related items with an expected life of more than two years, which are capitalized under generally accepted accounting principles. Such items shall include, but not be limited to, the following:

(A) Land, buildings, fixed equipment, major movable equipment and any attendant improvements thereto;

(B) The total cost of all studies, surveys, designs, plans, working drawings, specifications, and other activities essential to the acquisition, improvement, expansion or replacement of plant or equipment or any combination thereof;

(C) Leased assets. The purchase price for leased assets shall be the fair market value of the leased assets at the time of lease as determined by the office;

(D) Maintenance expenditures capitalized in accordance with generally accepted accounting principles or provided for as part of any lease, lease purchase agreement, purchase contract, or similar or related agreement; and

(E) Donated Assets. Donations of property and equipment, which under generally accepted accounting principles are or would normally be capitalized at fair market value at the date of contribution if purchased rather than donated;

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(9) “Case mix” means the average of inpatient cases, as differentiated by DRG, treated by a specific hospital during a given fiscal year;

(10) “Case mix index” means “case mix index” as defined in section 19a-659 of the Connecticut General Statutes;

(11) “Champus or Tricare” means “Champus or Tricare” as defined in section 19a-659 of the Connecticut General Statutes;

(12) “Charity care” means free or discounted health care services rendered by a hospital to persons who cannot afford to pay, including but not limited to, care to the uninsured patient or patients who are not expected to pay all or part of a hospital bill based on income guidelines and other financial criteria set forth in statute or in a hospital’s charity care policies on file at the office. Bad debts, courtesy discounts, contractual allowances, self pay discounts, and charges for health care services provided to employees are not included under the definition of charity care;

(13) “Contractual allowances” means the difference between hospital published charges and payments generated by negotiated agreements for a different or discounted rate or method of payment. Charity care and bad debts are not included under the definition of contractual allowances;

(14) “Cost center” means an expense classification, which identifies the salary, non-salary and depreciation expenses of a specific department or function. In addition, cost centers may be established to identify specific categories of expense such as interest, malpractice, leases, building and building equipment depreciation;

(15) “Current year” means the fiscal year consisting of a twelve month period, which is presently underway and which precedes the budget year. Also referred to as the base year;

(16) “CY” means current year;

(17) “Discharge” means any patient who was discharged on a date subsequent to the date admitted to the hospital for treatment as an inpatient; except that it shall also mean such patient was admitted and discharged on the same day where such patient:

(A) Died; or

(B) Left against medical advice; or

(C) Was formally released from the hospital.

For purposes of this definition, patients transferred between an exempt unit and any non-exempt inpatient unit shall be considered discharged and readmitted;

(18) “DRG” means Diagnosis Related Group;

(19) “Endowment funds” means funds in which a donor has stipulated, as a condition of his or her gift, that the principal amount of the fund is to be maintained inviolate and in perpetuity, and that only income from investments of the fund may be expended;

(20) “Equivalent discharges” means the result of multiplying inpatient discharges times the ratio of total gross revenue to inpatient gross revenue;

(21) “Exempt inpatient” means a psychiatric inpatient or a rehabilitation inpatient treated in a unit meeting the criteria set forth in 42 CFR 412.22(e), as from time to time amended;

(22) “Exempt Psychiatric Unit or Exempt Rehabilitation Unit” means respectively, an

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inpatient psychiatric unit or an inpatient rehabilitation unit of a general hospital that has been determined by Medicare as meeting the criteria set forth in 42 CFR 412.22(e), as from time to time amended;

(23) “Fiscal year” means:

(A) For each acute care general and children’s hospital, the fiscal year consisting of a twelve month period commencing on October 1st and ending the following September 30th; or

(B) For John Dempsey Hospital of the University of Connecticut Health Center, the hospital may elect to report on the basis of the hospital fiscal year defined in subparagraph (a), or may elect to operate and report to the office based on the state fiscal year consisting of a twelve month period commencing July 1st and ending the following June 30th. If John Dempsey Hospital chooses to operate and report to the office on a state fiscal year basis, the hospital shall comply with the provisions of section 19a-643-206 of the Regulations of Connecticut State Agencies as a continuing condition for qualifying to select or maintain the option of operating and reporting on a state fiscal year basis;

(24) “Funded depreciation” means funds specifically set aside for the replacement of capital assets;

(25) “FY” means fiscal year;

(26) “Government discharges” means discharges for which the principal payer is Medicare including Medicare sponsored managed care organizations, medical assistance including Medicaid and medical assistance sponsored managed care organizations, and Champus or Tricare. A discharge will be classified as a government discharge, if Medicare, medical assistance including Medicaid, Champus or Tricare is responsible for a majority of the cost of service rendered to the patient;

(27) “Gross inpatient revenue” means the total gross patient charges for hospital inpatient services consistent with Medicare principles of reimbursement;

(28) “Gross outpatient revenue” means the total gross patient charges for hospital outpatient services consistent with Medicare principles of reimbursement;

(29) “Gross revenue” means “Gross revenue” as defined in section 19a-659 of the Connecticut General Statutes;

(30) “Health Insurance Portability and Accountability Act of 1996” or “HIPAA” means Pub. L. 104-191 that, among other things, provides each person protections for maintaining health insurance when changing employment, coverage for preexisting conditions, and confidentiality of patient medical records;

(31) “Hospital” means a health care facility or institution licensed by the Department of Public Health to provide both inpatient and outpatient services as one of the following:

(A) A general hospital licensed by the Department of Public Health, including John Dempsey Hospital of the University of Connecticut Health Center, as a short-term, acute care general or children’s hospital; or

(B) a specialty hospital licensed by the Department of Public Health as a chronic disease hospital that provides inpatient psychiatric, rehabilitation or hospice services;

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(32) “Inpatient non-exempt” means inpatients who are not patients in an exempt psychiatric unit or exempt rehabilitation unit;

(33) “Managed care organization” means a “managed care organization” as defined in section 38a-1040 of the Connecticut General Statutes, or an eligible organization as defined by Medicare in 42 USC 1395mm (b) as from time to time amended, and which can also include health maintenance organizations (HMOs) and preferred provider organizations (PPOs);

(34) “Medicaid” means the federal and state health insurance program established under Title XIX of the Social Security Act to provide medical assistance on behalf of families with dependent children and for aged, blind, or disabled individuals, whose income and resources are insufficient to meet the costs of necessary medical services, and which is administered by the Department of Social Services pursuant to Chapter 319v of the Connecticut General Statutes;

(35) “Medical assistance” means “medical assistance” as defined in section 19a-659 of the Connecticut General Statutes;

(36) “Medical assistance underpayment” means “Medical assistance underpayment” as defined in section 19a-659 of the Connecticut General Statutes;

(37) “Medicare” means the federal health insurance program provided for the aged and disabled in 42 USC 1395 through 42 USC 1995 ccc, inclusive, as from time to time amended;

(38) “Medicare Cost Report” means Form 2552, the provider reimbursement report, any successor form and all supplemental schedules and attachments required to be filed annually pursuant to 42 CFR 413.20 (b) as from time to time amended;

(39) “Medicare principles of reimbursement” means the reimbursement principles provided in 42 CFR 413, and unless cited as of a specific date, shall incorporate any subsequent amendments;

(40) “Net revenue” means “net revenue” as defined in section 19a-659 of the Connecticut General Statutes;

(41) “Nongovernmental” means any commercial or private payer and includes, but is not limited, to managed care organizations, health maintenance organizations (HMOs) and preferred provider organizations (PPOs);

(42) “Non-operating revenue” means unrestricted revenue not directly derived from patient care, related patient services, or the sale of related goods and services. Non-operating revenue is further classified as revenue derived from either philanthropic or non-philanthropic sources;

(43) “Non-recurring items” means items from a base year or budget year that are not expected to occur again in the next fiscal year;

(44) “Office” means the Office of Health Care Access;

(45) “Operating expense” means the expenses necessary to maintain the functions of the hospital including, but not limited to, any collection agency or debt collection expense;

(46) “Other operating revenue” means revenue from non-patient goods and services.

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Such revenue should be normal to the operation of a hospital but should be accounted for separately from patient revenues and includes, but is not limited to, the following: revenue from gifts, grants, parking fees, recovery of silver from x-ray film, fees from educational programs, rental of health care facility space, sales from hospital gift shops, cafeteria meals, subsidies specified by the donor for research, educational or other programs, revenues restricted by the donor or grantor for operating purposes, and net assets released from restrictions. Bad debt recoveries shall not be considered to be other operating revenue;

(47) “Outlier” means a medicare case for which a federal intermediary has issued an additional payment beyond the applicable federal prospective payment rate as prescribed by the medicare program;

(48) “Outlier revenue” means the total revenue received by a hospital during a reporting period for all types of Medicare outliers;

(49) “Parent corporation” means a corporate holding company or a hospital health system that controls through its governing body a hospital and the hospital’s affiliates;

(50) “Payer classifications” means payers in the following categories:

(A) Nongovernmental: includes commercial and private payers;

(B) Champus or Tricare;

(C) Medicaid: includes medicaid contracted through medicaid managed care organizations;

(D) Medicare: includes medicare administered through designated fiscal intermediaries and carriers and medicare contracted through managed care organizations;

(E) Total medical assistance: includes medicaid and the state administered general assistance program contracted through general assistance managed care organizations;

(F) Other government payments: includes payments identified in 42 USC 701 through 42 USC 710, inclusive, as from time to time amended;

(G) Uninsured: includes individuals with no insurance; and

(H) Other;

(51) “Payer mix” means the proportionate share of itemized charges attributable to patients assignable to a specific payer classification to total itemized charges for all patients;

(52) “Plant replacement and expansion funds” means funds donated for renewal, expansion or replacement of existing plant or a portion of existing plant;

(53) “Preferred provider organization (PPO)” means a managed care organization, which provides health care coverage through leasing of contracts made with health care providers to insurers and employers for a fee, and which performs utilization review services;

(54) “Related corporation” means a corporation that is related to a hospital where the corporation is an affiliate or where the hospital has an ownership interest of ten per cent or more in the corporation or where the corporation has an ownership interest in the hospital of ten per cent or more;

(55) “Restricted funds” means funds temporarily or permanently restricted by donors for specific purposes. The term refers to specific purpose funds and endowment funds;

(56) “Retained earnings” means the portion of stockholders’ equity that accounts for the

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increase or decrease in contributed or paid-in capital due to net income, net losses and dividends paid;

(57) “Self-pay discount” means the amount discounted by a hospital from its published charges for, including but not limited to, an uninsured or underinsured patient from whom reimbursement is expected, as determined by the patient not having met the income guidelines and other financial criteria from the hospital’s charity care policies on file at the office;

(58) “Specific purpose funds” means funds restricted externally by a donor, or otherwise, for a specific purpose or project. Board-designated funds do not constitute specific purpose funds;

(59) “Stockholders’ equity” means the claims of ownership equity in an entity also known as contributed or paid-in capital, and retained earnings;

(60) “Temporarily restricted funds” means donated funds which by the terms of the gift become available either for any purpose designated by the governing board or for a specific purpose designated by the donor upon the happening of an event or upon the passage of a stated period of time;

(61) “Third party payer” means a governmental agency, or, private nongovernmental entity that is liable by virtue of state or federal law or regulation or a contract to pay for all or a part of the cost of a patient’s hospitalization or ambulatory services;

(62) “Uncompensated care” means “Uncompensated care” as defined in section 19a-659 of the Connecticut General Statutes;

(63) “Uninsured patient” means a patient who is without health insurance for whom the payer responsible for payment of the bill for hospital services rendered is the patient, the patient’s parent or guardian or another responsible person, who is not a third party payer and who is not subsequently reimbursed by another payer for the cost of any of the services rendered to the patient. A patient shall not be classified as an uninsured patient, if such subsequent reimbursement takes place;

(64) “Unrestricted funds” means funds which bear no external restrictions as to use or purpose and which can be used for any purpose, as distinguished from funds restricted externally for specific operating purposes, for plant replacement and expansion, or designated as endowment funds;

(65) “Volume” means the quantity of specified inpatient or outpatient utilization statistics; and

(66) “Working capital” means current assets excluding funds committed for the retirement of long term debt, minus current liabilities excluding the current portion of long term debt. All amounts due to or from other funds, affiliates or related organizations may be considered as current assets or current liabilities. The current portion of long term debt is excluded from this definition because it is treated separately in reviewing financial requirements.

(Transferred from § 19a-167g-55, November 1, 2007; Amended November 1, 2007; Amended April 9, 2013)

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Sec. 19a-643-202. Consistency

Unless otherwise specified, all financial information and statistical data submitted to the office in compliance with sections 19a-643-200 through 19a-643-206, inclusive, of the Regulations of Connecticut State Agencies shall be prepared in accordance with the following principles:

(a) “Consistency” means continued uniformity of reporting during a reporting period and from one reporting period to another in methods of accounting, valuation bases, methods of accrual and deferral, and statistical units of measure such as diagnosis related group relative weights. Any change in accounting procedures other than to comply with the filing requirements as prescribed by the office, which results in a lack of consistency and which is material in nature, must be brought to the attention of the office in a cover letter which will accompany the hospital’s submission. The cover letter shall include both a description and analysis of the impact that such accounting change has on the data submitted.

(b) “Depreciation policies” means the determination of the estimated useful life of a depreciable asset in its normal operating or service life. The useful lives of hospital assets shall be based on the most recent American Hospital Association’s useful life guidelines for depreciable assets.

(Transferred from § 19a-167g-52, November 1, 2007; Amended November 1, 2007)

Sec. 19a-643-203. Pricemaster

(a) A pricemaster, also known as a chargemaster, is the detailed schedule of all hospital charges that is required to be on file with the office in accordance with section 19a-681 of the Connecticut General Statutes.

(b) Each acute care general or children’s hospital shall file its most current pricemaster with the Office and shall be responsible for maintaining its accuracy and filing it in a timely manner. A hospital may start to charge for new drugs, supplies, tests and procedures that were not listed on its last hospital pricemaster filed with the office.

(Transferred from § 19a-167g-54, November 1, 2007; Amended November 1, 2007)

Sec. 19a-643-204. Filing of pricemaster data

(a) Each acute care general or children’s hospital shall file with the office a copy of the pricemaster that was in effect on the last day of the month by no later than the fifteenth calendar day of the following month, which shall include all new or revised charges not previously reported to the office. Pricemaster data shall be filed in an electronic format and medium specified by the office.

(b) Each pricemaster shall contain the following:

(1) A column for an item code number which shall uniquely identify each item in the pricemaster and shall be consistent with the item code utilized on the hospital’s detailed patient bills. This column shall be labeled “Item Code”;

(2) A column for an item description which shall uniquely describe each item in the pricemaster and shall be consistent with the item description utilized on the hospital’s

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detailed patient bills. This column shall be labeled “Item Description”; and

(3) A column for the item price in effect as of the last day of the month for which the pricemaster is applicable. This column shall be labeled “Item Price”.

(c) All pricemasters shall be filed with the office electronically in a format prescribed by the office. Each filing shall be accompanied by a cover letter that includes the month and year when the pricemaster took effect, the name of the file or files, and the name of the program used.

(d) A hospital may be subject to a civil penalty of \$500 per occurrence assessed by the office in accordance with section 19a-681 of the Connecticut General Statutes, if the hospital is found not to be in compliance with this section.

(Transferred from § 19a-167g-90, November 1, 2007; Amended November 1, 2007)

Sec. 19a-643-205. Hospital budget filing (Repealed)

Repealed April 9, 2013.

(Adopted effective November 1, 2007; Repealed April 9, 2013)

Sec. 19a-643-206. Annual reporting and twelve months actual filing

(a) Applicability to hospitals:

(1) Each acute care general or children’s hospital subject to the provisions of section 19a-644(a) of the Connecticut General Statutes shall report to the office by February 28th of each year with respect to its operations for the most recently completed fiscal year in such form as the office may require; and

(2) Each specialty hospital subject to the provisions of section 19a-644(d) of the Connecticut General Statutes shall report to the office by the end of the fifth month after the hospital’s fiscal year ending date. The specialty hospital shall submit audited financial statements that are general purpose financial statements, which express the unqualified opinion of an independent certified public accounting firm for the most recently completed fiscal year for the hospital, or audited consolidated financial statements for the hospital’s parent corporation and consolidating financial statements that at a minimum contain a balance sheet and statement of operations and that provide a breakout of the hospital’s and each affiliate’s numbers with a report of independent accountants on other financial information.

(b) Content of Annual Reporting: The hospital’s annual report for the most recently completed fiscal year shall consist of the following required information components to be submitted annually to the office by February 28th in accordance with sections 19a-509b (f), 19a-644, 19a-649 and 19a-673c of the Connecticut General Statutes:

(1) Audited financial statements that are general purpose financial statements, which express the unqualified opinion of an independent certified public accounting firm for the most recently completed fiscal year for the hospital, each of its affiliates except for those affiliates that were inactive or that had an immaterial amount of total assets, and the hospital’s parent corporation that include the following:

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- (A) A separately bound original submitted by an independent certified public accounting firm and also a PDF version in Adobe Acrobat of all audited financial statements submitted;
- (B) A note in the hospital's audited financial statements that identifies individual amounts for the hospital's gross patient revenue, allowances, charity care and net patient revenue;
- (C) Audited consolidated financial statements for hospitals with subsidiaries and consolidating financial statements that at a minimum contain a balance sheet and statement of operations and that provide a breakout of the hospital's and each subsidiary's numbers with a report of independent accountants on other financial information; and
- (D) Audited consolidated financial statements for the hospital's parent corporation and consolidating financial statements that at a minimum contain a balance sheet and statement of operations and that provide a breakout of the hospital's and each affiliate's numbers with a report of independent accountants on other financial information;
- (2) The Medicare cost report for the most recently completed fiscal year, as filed in electronic media format, and any final audited Medicare cost reports for prior fiscal years submitted on paper, which have not been previously submitted to the office;
- (3) The most recent legal chart of corporate structure including the hospital, each of its affiliates and subsidiaries and its parent corporation, duly dated;
- (4) Separate current lists of officers and directors for the hospital, each of its affiliates and its parent corporation as of the February 28th annual reporting submission date;
- (5) A report that identifies by purpose, the ending fund balances of the net assets of the hospital and each affiliate as of the close of the most recently completed fiscal year, distinguishing between donor permanently restricted, donor temporarily restricted, board restricted and unrestricted fund balances. The hospital's interest in its foundation shall be deducted from the foundation's total fund balance;
- (6) A report that identifies all transactions between the hospital and each of its affiliates during the most recently completed fiscal year including, but not limited to, the amount of any transfers of funds, transfers of assets, and sales/purchases of services or commodities, and all transactions between affiliates;
- (7) A report that identifies all expenditures incurred by each affiliate for the benefit of the hospital, e.g., subsidized housing for staff, during the most recently completed fiscal year, and the amount of any such expenditures;
- (8) A report that identifies all commitments or endorsements entered into by the hospital for the benefit of each affiliate;
- (9) The total number of discharges and the related number of patient days by town of origin, based on zip code and diagnostic category for the most recently completed fiscal year accounting for 100 percent of total discharges and related patient days;
- (10) The average length of stay and length of stay range by diagnostic category, age grouping and expected payer source;
- (11) The total number of discharges to a residence, a home health agency, another hospital, a skilled nursing facility, an intermediate care facility and to all other locations;
- (12) The total number of inpatient surgical procedures by diagnosis, principal surgical

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procedure and age grouping with the related number of cases and patient days;

(13) Outpatient surgical procedures including ambulatory surgery by principal surgical procedure and age grouping with the related number of cases. For purposes of this section, ambulatory surgery is defined as surgical patient admissions discharged prior to the midnight census on the day of admission after the patient has undergone a surgical procedure requiring the use of a fully equipped operating room, i.e. one equipped to administer general anesthesia, whether or not the patient is admitted to a discrete ambulatory or same day surgery unit;

(14) Case mix and revenue support schedules in a format acceptable to the office. Case mix shall be reported by identifying the number of discharges in each DRG. Revenue support schedules shall include identification of gross charges by payer classification for each DRG;

(15) Information concerning uncompensated care that includes a copy of the hospital's policies and procedures related to charity care and bad debts that were in effect for the hospital's most recently completed fiscal year;

(16) A report identifying all donations and funds, which are or have been restricted for the care of indigent patients at the end of the most recently completed fiscal year. The report shall include, but is not limited to, information which identifies the principal balance and all earned income for the previous year, as well as, projected interest income expected to be earned during the current fiscal year;

(17) A report from each hospital that holds or administers one or more hospital bed funds that is maintained and annually compiled by the hospital for the most recently completed fiscal year, and that is permanently retained by the hospital and, upon the office's request, provides the following fiscal year information:

(A) the number of applications for hospital bed funds;

(B) the number of patients receiving hospital bed fund grants and the actual amounts provided to each patient from such funds;

(C) the fair market value of the principal of each individual hospital bed fund, or the principal attributable to each bed fund if held in a pooled investment;

(D) the total earnings for each hospital bed fund or the earnings attributable to each hospital bed fund;

(E) the dollar amount of earnings reinvested as principal, if any; and

(F) the dollar amount of earnings available for patient care;

(18) A report that provides the following hospital debt collection information:

(a) whether the hospital uses a collection agent to assist with debt collection;

(b) the name of any collection agent used by the hospital;

(c) the hospital's processes and policies for assigning a debt to a collection agent and for compensating such collection agent for services rendered, and

(d) the recovery rate on accounts assigned to collection agents, exclusive of Medicare accounts, for the hospital's most recently completed fiscal year;

(19) A report listing the salaries and fringe benefits for the ten highest paid positions in

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the hospital. Each position shall be identified by its complete, unabbreviated title. Fringe benefits shall include all forms of compensation whether actual or deferred, made to or on behalf of the employee whether full or part-time. Fringe benefits shall include but not be limited to the following:

(A) The cost to the hospital of all health, life, disability or other insurance or benefit plans;

(B) The cost of any employer payments or liability to employee retirement plans or programs;

(C) The cost or value of any bonus, incentive or longevity plans not included under normal salary reporting guidelines;

(D) The cost or value of any housing, whether in the form of a house, apartment, condominium, dormitory or room of any type, whether full-time or only available for part-time use, if subsidized in full or in part by the hospital and not located directly within a hospital building offering direct patient care;

(E) The fair market value of any office space, furnishings, telephone service, support service staff, support service equipment, billing or collection services or similar benefits provided to any person for use when seeing non-hospital or private patients or clients. This value shall be prorated based on the total number of hospital and non-hospital patient billing units or provider man-hours involved. For purposes of this subparagraph, if both hospital and non-hospital clients are served from the same location, hospital patients are defined as patients who are billed directly by the hospital for the service provided and for whom the hospital retains the full payment received as part of its gross operating revenue;

(F) the fair market value of the cost or subsidy of the use of any automobile, transportation tickets or passes, free or reduced parking, travel expenses, hotel accommodations, etc.; and

(G) Any items of value available to employees and not specifically listed above;

(20) A report containing the following:

(A) The full name of the hospital and each joint venture, partnership and related corporation affiliated with the hospital;

(B) The name and address of the chief executive officer of the hospital and each affiliate listed under this subdivision;

(C) The name and address of the Connecticut agent for service for the hospital and each affiliate listed under this subdivision; and

(D) A brief description of what each affiliate is, does or proposes to do and the type of services provided or functions performed;

(21) A report containing the salaries and the fair market value of any fringe benefits paid to hospital employees by each joint venture, partnership and related corporation, either directly or indirectly, and by the hospital to the employees of any of its affiliates. Indirect payments include, but are not limited to, payments made to each affiliate. For purposes of this section, a hospital employee is anyone who provides a service, which incurs an expense for the hospital; and

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(22) A report of all transfers of assets, transfers of operations or changes of control involving the hospital's clinical or nonclinical services or functions from the hospital to a person or entity organized or operated on a for profit basis.

(c) **Content of Twelve Months Actual Filing.** The hospital's twelve months actual filing for the most recently completed fiscal year shall consist of the following required information components to be submitted annually to the Office by March 31st in accordance with sections 19a-649 and 19a-676 of the Connecticut General Statutes:

(1) Medicare managed care inpatient and outpatient charges, payments, discharges and patient days by payer;

(2) Medicaid managed care and medical assistance non-managed care inpatient and outpatient charges, payments, discharges and patient days by payer;

(3) Charity care, bad debts and total uncompensated care;

(4) Non-government payers' discount percentages, gross revenue, contractual allowances and payments either in total or by payer;

(5) Operating revenue and expenses including, but not limited to, gross revenue, deductions from gross revenue, other operating revenue, operating expenses and non-operating revenue;

(6) Discharges by DRG and the calculation of case mix adjusted discharges and case mix index;

(7) Inpatient and outpatient utilization statistics by service including licensed and staffed beds and percentage of occupancy, inpatient gross revenue and utilization statistics by payer, outpatient gross revenue by payer, total full time equivalent employees, and other services utilization statistics;

(8) Data inputs from hospital external source reports and external and internal source data reconciliations that include the reconciliation of data items from inputs of specific balance sheet, statement of operations and utilization statistics information and any other data contained in the hospital's most recent Medicare cost report and audited financial statements;

(9) A summary of gross revenue, net revenue, other operating revenue, revenue from operations, operating expenses, utilization statistics, case mix index, full time equivalent employees and related statistical analyses;

(10) Data inputs for inpatient and outpatient accrued charges and payments, payer mix, accrued discharges and patient days, average length of stay, case mix index and other required data elements used to calculate the disproportionate share hospital program underpayment calculations;

(11) A summary of inpatient and outpatient accrued charges and payments, accrued discharges, case mix index, other required data elements and a net revenue reconciliation to net revenue as defined by the office;

(12) A report providing the number of applicants for charity and reduced cost services, the number of approved applicants, and the total and average charges and costs of the amount of charity and reduced cost care provided; and

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(13) A report of independent certified public accountants on applying agreed-upon procedures that provides the results of an independent audit of the level of charges, payments and discharges by primary payer related to Medicare, Medicaid, medical assistance, Champus, Tricare and non-governmental payers and the amount of Charity care and bad debts.

(d) A hospital requesting a partial waiver of the information required to be submitted to the office by an affiliate must request the waiver at least thirty (30) calendar days prior to the due date of the required submission. The waiver request must include the following:

(1) A legal chart of corporate structure showing the hospital and each of its affiliates and the lines of reporting authority and control;

(2) The name, address, title and telephone number of the President and Chief Executive Officer of each affiliate;

(3) A list identifying each affiliate for which a waiver of informational filings is requested, specifically identifying the filings to which the request pertains, when they are due, and the reasons for the request; and

(4) A statement signed under penalty of false statement by the President and Chief Executive Officer of the Connecticut hospital for each affiliate listed in (3) above, which states that the affiliate for which the partial waiver is requested:

(A) Does not direct or control the Connecticut hospital seeking the partial waiver; and

(B) Does not do business with or share facilities, finances, personnel or services with the Connecticut hospital; and

(C) Is not located in Connecticut and does not do business in Connecticut; or

(D) Has provided an explanation of why the hospital should be given a waiver of some or all of the affiliate's filing requirements even though (A), (B), or (C) above do not apply. The explanation shall include details of the extent to which (A), (B) and/or (C) do apply.

(Transferred from § 19a-167g-91, November 1, 2007; Amended November 1, 2007)

Office of Healthcare Access Rules of Practice

Sec. 19a-643-207. Rules of practice

The Office of Health Care Access division of the Department of Public Health shall follow the Rules of Practice under section 19a-9-1, et seq., of the Regulations of Connecticut State Agencies.

(Effective April 9, 2013)

Sec. 19a-643-208. Consolidation of proceedings

Proceedings involving related questions of law or fact may be consolidated at the direction of the commissioner, the commissioner's designee or a presiding officer.

(Effective April 9, 2013)

*****THE DOCUMENT HAS ERRORS*****

1. There is overmatter content.Check annotations in PDF rendition
2. There is overmatter content.Check annotations in PDF rendition
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Agency

Department of Public Health

Subject

Civil Penalties Assessed by the Office of Healthcare Access

Inclusive Sections

§§ 19a-653-1—19a-653-4

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Civil Penalties Assessed by the Office of Healthcare Access

Sec. 19a-653-1. Notification of a civil penalty

The commissioner or the commissioner's designee, prior to the imposition of any civil penalty under section 19a-653 of the Connecticut General Statutes, shall notify any facility, institution or person subject to such civil penalty in accordance with section 19a-653 of the Connecticut General Statutes.

(Effective April 9, 2013)

Sec. 19a-653-2. Civil penalty – request for hearing

Pursuant to section 19a-653 of the Connecticut General Statutes, any health care facility or person to whom the notice of civil penalty was addressed may request a hearing to contest the imposition of the civil penalty. The Office shall notify the health care facility or person of the date, time and place of the hearing, not later than ten days after the Office's receipt of the request.

(Effective April 9, 2013)

Sec. 19a-653-3. Civil penalty – request for extension of time

(a) A request for an extension of time within which to file required data or information shall contain the following:

(1) The reason why the health care facility or person was unable to comply with the original due date; and

(2) The date on which the information or data will be filed.

(b) In reviewing the request for an extension of time, the Office shall consider the following:

(1) Any extenuating circumstances that prevented compliance with the original due date;

(2) Demonstration of a good faith effort to comply with the appropriate statute, act, order, or regulations;

(3) Past history of compliance with the submission of data or information requirements;

(4) The length of the delay in filing;

(5) The degree of incompleteness or inaccuracy; and

(6) Any other relevant criteria.

(c) If the request for an extension of time is granted, it shall be granted to a date certain. Failure to submit the required data or information by that extended date may result in the imposition of a civil penalty beginning on the day after the extended due date. The civil penalty shall become effective upon the expiration of the time extension and OHCA shall provide notice of the same to the person or health care facility.

(Effective April 9, 2013)

Sec. 19a-653-4. Rescission of civil penalty

Upon receipt of the data or information or the filing of a certificate of need, the Office

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may rescind the civil penalty in whole or in part.

(Effective April 9, 2013)