

XIV. TB-Related Laws

A. General Statutes

1) § 15A-534.5. Detention To Protect Public Health

If a judicial official conducting an initial appearance finds by clear and convincing evidence that a person arrested for violation of an order limiting freedom of movement or access issued pursuant to G.S. 130A-475 or G.S. 130A-145 poses a threat to the health and safety of others, the judicial official shall deny pretrial release and shall order the person to be confined in an area or facility designated by the judicial official. Such pretrial confinement shall terminate when a judicial official determines that the confined person does not pose a threat to the health and safety of others. These determinations shall be made only after the State Health Director or local health director has made recommendations to the court. (2002-179, s. 15.)

2) § 90-21.4. Responsibility, liability and immunity of physicians.

(a) Any physician licensed to practice medicine in North Carolina providing health services to a minor under the terms, conditions and circumstances of this Article shall not be held liable in any civil or criminal action for providing such services without having obtained permission from the minor's parent, legal guardian, person standing in loco parentis, or a legal custodian other than a parent when granted specific authority in a custody order to consent to medical or psychiatric treatment. The physician shall not be relieved on the basis of this Article from liability for negligence in the diagnosis and treatment of a minor.

(b) The physician shall not notify a parent, legal guardian, person standing in loco parentis, or a legal custodian other than a parent when granted specific authority in a custody order to consent to medical or psychiatric treatment, without the permission of the minor, concerning the medical health services set out in G.S. 90-21.5(a), unless the situation in the opinion of the attending physician indicates that notification is essential to the life or health of the minor. If a parent, legal guardian[,] person standing in loco parentis, or a legal custodian other than a parent when granted specific authority in a custody order to consent to medical or psychiatric treatment contacts the physician concerning the treatment or medical services being provided to the minor, the physician may give information. (1965, c. 810, s. 4; 1977, c. 582, s. 1; 1985, c. 589, s. 30.)

3) § 90-21.5. Minor's Consent Sufficient For Certain Medical Health Services.

(a) Any minor may give effective consent to a physician licensed to practice medicine in North Carolina for medical health services for the prevention, diagnosis and treatment of

- (i) venereal disease and other diseases reportable under G.S. 130A-135,
- (ii) pregnancy,
- (iii) abuse of controlled substances or alcohol, and
- (iv) emotional disturbance.

This section does not authorize the inducing of an abortion, performance of a sterilization operation, or admission to a 24-hour facility licensed under Article 2 of Chapter 122C of the General Statutes except as provided in G.S. 122C-222. This section does not prohibit the admission of a minor to a treatment facility upon his

own written application in an emergency situation as authorized by G.S. 122C-222.

(b) Any minor who is emancipated may consent to any medical treatment, dental and health services for himself or for his child.

History (1971, c. 35; 1977, c. 582, s. 2; 1983, c. 302, s. 2; 1985, c. 589, s. 31; 1985 (Reg. Sess., 1986), c. 863, s. 4.) Annotations

CASE NOTES

A state cannot require a minor to obtain parental consent for an abortion unless it provides an alternative procedure whereby authorization can be obtained for the abortion. North Carolina has no such alternative procedure. *Wilkie v. Hoke*, 609 F. Supp. 241 (W.D.N.C. 1985).

Minor plaintiff's common law ability to void agreement to arbitrate, one of the provisions of an informed consent form which she signed in consenting to an abortion, was not changed by statute and did not deprive her of her constitutional right to an abortion. *Wilkie v. Hoke*, 609 F. Supp. 241 (W.D.N.C. 1985).

OPINIONS OF ATTORNEY GENERAL

This Section Does Not Conflict with G.S. 7B-3400. - Section 7B-3400, which provides that minors are subject to the supervision and control of their parents "notwithstanding any other provision of law," does not abrogate G.S. 90-21.5, which specifies the circumstances under which minors can consent to health services as the statutes address different issues and do not conflict with one another. See opinion of Attorney General to Dr. David King, Chairman, Rowan Board of Health, 1999 N.C. AG LEXIS 27 (8/25/99).

4) § 90-85.34A. Public Health Pharmacy Practice

(a) A registered nurse in a local health department clinic may dispense prescription drugs and devices, other than controlled substances as defined in G.S. 90-87, under the following conditions:

- (1) The registered nurse has training acceptable to the Board in the labeling and packaging of prescription drugs and devices;
- (2) Dispensing by the registered nurse shall occur only at a local health department clinic;
- (3) Only prescription drugs and devices contained in a formulary recommended by the Department of Health and Human Services and approved by the Board shall be dispensed;
- (4) The local health department clinic shall obtain a pharmacy permit in accordance with G.S. 90-85.21;
- (5) Written procedures for the storage, packaging, labeling and delivery of prescription drugs and devices shall be approved by the Board; and
- (6) The pharmacist-manager, or another pharmacist at his direction, shall review dispensing records at least weekly, provide consultation where appropriate, and be responsible to the Board for all dispensing activity at the local health department clinic.

(b) This section is applicable only to prescriptions issued on behalf of persons receiving local health department clinic services and issued by an individual authorized by law to prescribe drugs and devices.

(c) This section does not affect the practice of nurse practitioners pursuant to G.S. 90-18.2 or of physician assistants pursuant to G.S. 90-18.1. (1985, c. 359; 1989 (Reg. Sess., 1990), c. 1004, s. 2; 1997-443, s. 11A.22.)

5) § 115C-323. Employee Health Certificate. (Public School Employee)

(a) Any person initially employed in a public school or reemployed in a public school after an absence of more than one school year shall provide to the superintendent a certificate certifying that the person does not have any physical or mental disease, including tuberculosis in the communicable form or other communicable disease that would impair the person's ability to perform his or her duties effectively. A local board or a superintendent may require any school employee to take a physical examination when considered necessary. Any public school employee who has been absent for more than 40 successive school days because of a communicable disease shall, before returning to work, provide to the superintendent a certificate certifying that the individual is free from any communicable disease.

(b) One of the following individuals shall prepare any certificate required under this section:

- (1) A physician licensed to practice in North Carolina.
- (2) A nurse practitioner approved under G.S. 90-18(14).
- (3) A physician's assistant licensed to practice in North Carolina.

(c) Notwithstanding subsection (b) of this section, in the case of a person initially employed in a public school, any of the following who holds a current unrestricted license or registration in another state may prepare the certificate so long as evidence of that license or registration is on the certificate:

- (1) A physician.
- (2) A nurse practitioner.
- (3) A physician's assistant.

(d) The certificate shall be prepared on a form supplied by the Superintendent of Public Instruction. The certificate shall be issued only after a physical examination has been conducted, at the time of the certification, in accordance with rules adopted by the Superintendent of Public Instruction, with approval of the Secretary of Health and Human Services. These rules may require an X-ray chest examination for all new employees of the public school system.

(e) It shall be the duty of the superintendent of the school in which the person is employed to enforce the provisions of this section. Any person violating any of the provisions of this

section shall be guilty of a Class 1 misdemeanor. (1955, c. 1372, art. 17, s. 1; 1957, c. 1357, ss. 2, 14; 1973, c. 476, s. 128; 1975, c. 72; 1981, c. 423, s. 1; 1985 (Reg. Sess., 1986), c. 975, s. 20; 1991, c. 342, s. 4; 1993, c. 539, s. 886; 1994, Ex. Sess., c. 24, s. 14(c); 1997-443, s. 11A.50; 2001-118, s.

6) § 130A-25. Misdemeanor.

(a) Except as otherwise provided, a person who violates a provision of this Chapter or the rules adopted by the Commission or a local board of health shall be guilty of a misdemeanor.

(b) A person convicted under this section for violation of G.S. 130A-144(f) or G.S. 130A-145 shall not be sentenced under Article 81B of Chapter 15A of the General Statutes but shall instead be sentenced to a term of imprisonment of no

more than two years and shall serve any prison sentence in McCain Hospital, Section of Prisons of the Division of Adult Correction, McCain, North Carolina; the North Carolina Correctional Center for Women, Section of Prisons of the Division of Adult Correction, Raleigh, North Carolina; or any other confinement facility designated for this purpose by the Secretary of Public Safety after consultation with the State Health Director. The Secretary of Public Safety shall consult with the State Health Director concerning the medical management of these persons.

(c) Notwithstanding G.S. 148-4.1, G.S. 148-13, or any other contrary provision of law, a person imprisoned for violation of G.S. 130A-144(f) or G.S. 130A-145 shall not be released prior to the completion of the person's term of imprisonment unless and until a determination has been made by the District Court that release of the person would not create a danger to the public health. This determination shall be made only after the medical consultant of the confinement facility and the State Health Director, in consultation with the local health director of the person's county of residence, have made recommendations to the Court.

(d) A violation of Part 7 of Article 9 of this Chapter or G.S. 130A-309.10(m) shall be punishable as a Class 3 misdemeanor. (1983, c. 891, s. 2; 1987, c. 782, s. 19; 1991, c. 187, s. 1; 1993, c. 539, s. 946; 1994, Ex. Sess., c. 24, s. 14(c); 1993 (Reg. Sess., 1994), c. 767, s. 18; 2010-180, s. 14(d); 2011-145, s. 19.1(h), (i), (j).)

7) § 130A-134. Reportable Diseases And Conditions

The Commission shall establish by rule a list of communicable diseases and communicable conditions to be reported. (1983, c. 891, s. 2; 1987, c. 782, s. 4.)

8) § 130A-135. Physicians To Report

A physician licensed to practice medicine who has reason to suspect that a person about whom the physician has been consulted professionally has a communicable disease or communicable condition declared by the Commission to be reported, shall report information required by the Commission to the local health director of the county or district in which the physician is consulted. The Commission shall declare confirmed HIV infection to be a reportable communicable condition. (1893, c. 214, s. 11; Rev., s. 3448; 1917, c. 263, s. 7; C.S., s. 7151; 1921, c. 223, s. 1; 1957, c. 1357, s. 1; 1973, c. 476, s. 128; 1983, c. 891, s. 2; 1987, c. 782, s. 5; 1989, c. 698, s. 3.)

9) § 130A-136. School Principals And Child Care Operators To Report

A principal of a school and an operator of a child care facility, as defined in G.S. 110-86(3), who has reason to suspect that a person within the school or child care facility has a communicable disease or communicable condition declared by the Commission to be reported, shall report information required by the Commission to the local health director of the county or district in which the school or facility is located. (1979, c.192, s. 2; 1983, c. 891, s. 2; 1987, c. 782, s. 6; 1997-506, s. 46.)

10) § 130A-137. Medical Facilities May Report

A medical facility, in which there is a patient reasonably suspected of having a communicable disease or condition declared by the Commission to be reported, may report information specified by the Commission to the local health director of

the county or district in which the facility is located. (1983, c. 891, s. 2; 1987, c. 782, s. 7.)

11) § 130A-139. Persons In Charge Of Laboratories To Report.

A person in charge of a laboratory providing diagnostic service in this State shall report information required by the Commission to a public health agency specified by the Commission when the laboratory makes any of the following findings:

- (1) Sputa, gastric contents, or other specimens which are smear positive for acid fast bacilli or culture positive for Mycobacterium tuberculosis;
- (2) Urethral smears positive for Gram-negative intracellular diplococci or any culture positive for Neisseria gonorrhoea;
- (3) Positive serological tests for syphilis or positive darkfield examination;
- (4) Any other positive test indicative of a communicable disease or communicable condition for which laboratory reporting is required by the Commission. (1981, c. 81, s. 1; 1983, c. 891, s. 2; 1987, c. 782, s. 9; 2001-28, s. 1.)

12) § 130A-140. Local Health Directors To Report

A local health director shall report to the Department all cases of diseases or conditions or laboratory findings of residents of the jurisdiction of the local health department which are reported to the local health director pursuant to this Article. A local health director shall report all other cases and laboratory findings reported pursuant to this Article to the local health director of the county, district, or authority where the person with the reportable disease or condition or laboratory finding resides. (1919, c. 206, s. 2; C.S., s. 7192; 1957, c. 1357, s. 1; 1961, c. 753; 1973, c. 476, s. 128; 1983, c. 891, s. 2; 1987, c. 782, s. 10; 1997-502, s. 10.)

13) § 130A-141. Form, Content And Timing Of Reports

The Commission shall adopt rules which establish the specific information to be submitted when making a report required by this Article, time limits for reporting, the form of the reports and to whom reports of laboratory findings are to be made. (1983, c. 891, s. 2; 1987, c. 782, s. 11.)

14) § 130A-141.1 Temporary Order to Report

- 1) The State Health Director may issue a temporary order requiring health care providers to report symptoms, diseases, conditions, trends in use of health care services, or other health-related information when necessary to conduct a public health investigation or surveillance of an illness, condition, or symptoms that may indicate the existence of a communicable disease or condition that presents a danger to the public health. The order shall specify which health care providers must report, what information is to be reported, and the period of time for which reporting is required. The period of time for which reporting is required pursuant to a temporary order shall not exceed 90 days. The Commission may adopt rules to continue the reporting requirement when necessary to protect the public health.
- 2) For the purposes of this section, the term 'health care provider' has the same meaning as that term is defined in G.S. 130A-476(g). (ratified 1st day of July, 2004)

15) § 130A-142. Immunity Of Persons Who Report

A person who makes a report pursuant to the provisions of this Article shall be immune from any civil or criminal liability that might otherwise be incurred or imposed as a result of making that report. (1983, c. 891, s. 2; 1987, c. 782, s. 12.)

16) § 130A-143. Confidentiality of records.

All information and records, whether publicly or privately maintained, that identify a person who has AIDS virus infection or who has or may have a disease or condition required to be reported pursuant to the provisions of this Article shall be strictly confidential. This information shall not be released or made public except under the following circumstances:

- (1) Release is made of specific medical or epidemiological information for statistical purposes in a way that no person can be identified;
- (2) Release is made of all or part of the medical record with the written consent of the person or persons identified or their guardian;
- (3) Release is made for purposes of treatment, payment, research, or health care operations to the extent that disclosure is permitted under 45 Code of Federal Regulations §§ 164.506 and 164.512(i). For purposes of this section, the terms "treatment," "payment," "research," and "health care operations" have the meaning given those terms in 45 Code of Federal Regulations § 164.501;
- (4) Release is necessary to protect the public health and is made as provided by the Commission in its rules regarding control measures for communicable diseases and conditions;
- (5) Release is made pursuant to other provisions of this Article;
- (6) Release is made pursuant to subpoena or court order. Upon request of the person identified in the record, the record shall be reviewed in camera. In the trial, the trial judge may, during the taking of testimony concerning such information, exclude from the courtroom all persons except the officers of the court, the parties and those engaged in the trial of the case;
- (7) Release is made by the Department or a local health department to a court or a law enforcement official for the purpose of enforcing this Article or Article 22 of this Chapter, or investigating a terrorist incident using nuclear, biological, or chemical agents. A law enforcement official who receives the information shall not disclose it further, except (i) when necessary to enforce this Article or Article 22 of this Chapter, or when necessary to conduct an investigation of a terrorist incident using nuclear, biological, or chemical agents, or (ii) when the Department or a local health department seeks the assistance of the law enforcement official in preventing or controlling the spread of the disease or condition and expressly authorizes the disclosure as necessary for that purpose;
- (8) Release is made by the Department or a local health department to another federal, state or local public health agency for the purpose of preventing or controlling the spread of a communicable disease or communicable condition;
- (9) Release is made by the Department for bona fide research purposes. The Commission shall adopt rules providing for the use of the information for research purposes;
- (10) Release is made pursuant to G.S. 130A-144(b); or
- (11) Release is made pursuant to any other provisions of law that specifically authorize or require the release of information or records related to AIDS. (1983, c. 891, s. 2; 1987, c. 782, s. 13; 2002-179, s. 7; 2011-314, s. 4.)

17) § 130A-144. Investigation and control measures.

- (a) The local health director shall investigate, as required by the Commission, cases of communicable diseases and communicable conditions reported to the local health director pursuant to this Article.
- (b) Physicians, persons in charge of medical facilities or laboratories, and other persons shall, upon request and proper identification, permit a local health director or the State Health Director to examine, review, and obtain a copy of medical or other records in their possession or under their control which the State Health Director or a local health director determines pertain to the (i) diagnosis, treatment, or prevention of a communicable disease or communicable condition for a person infected, exposed, or reasonably suspected of being infected or exposed to such a disease or condition, or (ii) the investigation of a known or reasonably suspected outbreak of a communicable disease or communicable condition.
- (c) A physician or a person in charge of a medical facility or laboratory who permits examination, review or copying of medical records pursuant to subsection (b) shall be immune from any civil or criminal liability that otherwise might be incurred or imposed as a result of complying with a request made pursuant to subsection (b).
- (d) The attending physician shall give control measures prescribed by the Commission to a patient with a communicable disease or communicable condition and to patients reasonably suspected of being infected or exposed to such a disease or condition. The physician shall also give control measures to other individuals as required by rules adopted by the Commission.
- (e) The local health director shall ensure that control measures prescribed by the Commission have been given to prevent the spread of all reportable communicable diseases or communicable conditions and any other communicable disease or communicable condition that represents a significant threat to the public health. The local health department shall provide, at no cost to the patient, the examination and treatment for tuberculosis disease and infection and for sexually transmitted diseases designated by the Commission.
- (f) All persons shall comply with control measures, including submission to examinations and tests, prescribed by the Commission subject to the limitations of G.S. 130A-148.
- (g) The Commission shall adopt rules that prescribe control measures for communicable diseases and conditions subject to the limitations of G.S. 130A-148. Temporary rules prescribing control measures for communicable diseases and conditions shall be adopted pursuant to G.S. 150B-13.
- (h) Anyone who assists in an inquiry or investigation conducted by the State Health Director for the purpose of evaluating the risk of transmission of HIV or Hepatitis B from an infected health care worker to patients, or who serves on an expert panel established by the State Health Director for that purpose, shall be immune from civil liability that otherwise might be incurred or imposed for any acts or omissions which result from such assistance or service, provided that the person acts in good faith and the acts or omissions do not amount to gross negligence, willful or wanton misconduct, or intentional wrongdoing. This qualified immunity does not apply to acts or omissions which occur with respect to the operation of a motor vehicle. Nothing in this subsection provides immunity from liability for a violation of G.S. 130A-143. (1893, c. 214, s. 16; Rev., s. 4459; 1909, c. 793, s. 8; C.S., s. 7158; 1957, c. 1357, s. 1; 1973, c. 476, s. 128; 1983, c. 891, s. 2; 1987, c. 782, s. 14; 1991, c. 225, s. 1; 1995, c. 228, s. 1; 2001-28, s. 2; 2004-80, s. 6; 2009-501, s. 2.)

18) § 130A-145. Quarantine And Isolation Authority

(a) The State Health Director and a local health director are empowered to exercise quarantine and isolation authority. Quarantine and isolation authority shall be exercised only when and so long as the public health is endangered, all other reasonable means for correcting the problem have been exhausted, and no less restrictive alternative exists.

(b) No person other than a person authorized by the State Health Director or local health director shall enter quarantine or isolation premises. Nothing in this subsection shall be construed to restrict the access of authorized health care, law enforcement, or emergency medical services personnel to quarantine or isolation premises as necessary in conducting their duties.

(c) Before applying quarantine or isolation authority to livestock or poultry for the purpose of preventing the direct or indirect conveyance of an infectious agent to persons, the State Health Director or a local health director shall consult with the State Veterinarian in the Department of Agriculture and Consumer Services.

(d) When quarantine or isolation limits the freedom of movement of a person or animal or of access to a person or animal whose freedom of movement is limited, the period of limited freedom of movement or access shall not exceed 30 calendar days. Any person substantially affected by that limitation may institute in superior court in Wake County or in the county in which the limitation is imposed an action to review that limitation. The official who exercises the quarantine or isolation authority shall give the persons known by the official to be substantially affected by the limitation reasonable notice under the circumstances of the right to institute an action to review the limitation. If a person or a person's representative requests a hearing, the hearing shall be held within 72 hours of the filing of that request, excluding Saturdays and Sundays. The person substantially affected by that limitation is entitled to be represented by counsel of the person's own choice or if the person is indigent, the person shall be represented by counsel appointed in accordance with Article 36 of Chapter 7A of the General Statutes and the rules adopted by the Office of Indigent Defense Services. The court shall reduce or terminate the limitation unless it determines, by the preponderance of the evidence, that the limitation is reasonably necessary to prevent or limit the conveyance of a communicable disease or condition to others. If the State Health Director or the local health director determines that a 30-calendar-day limitation on freedom of movement or access is not adequate to protect the public health, the State Health Director or local health director must institute in superior court in the county in which the limitation is imposed an action to obtain an order extending the period of limitation of freedom of movement or access. If the person substantially affected by the limitation has already instituted an action in superior court in Wake County, the State Health Director must institute the action in superior court in Wake County or as a counterclaim in the pending case. Except as provided below for persons with tuberculosis, the court shall continue the limitation for a period not to exceed 30 days if it determines, by the preponderance of the evidence, that the limitation is reasonably necessary to prevent or limit the conveyance of a communicable disease or condition to others. The court order shall specify the period of time the limitation is to be continued and shall provide for automatic termination of the order upon written determination by the State Health Director or local health director that the quarantine or isolation is no longer necessary to protect the public health. In

addition, where the petitioner can prove by a preponderance of the evidence that quarantine or isolation was not or is no longer needed for protection of the public health, the person quarantined or isolated may move the trial court to reconsider its order extending quarantine or isolation before the time for the order otherwise expires and may seek immediate or expedited termination of the order. Before the expiration of an order issued under this section, the State Health Director or local health director may move to continue the order for additional periods not to exceed 30 days each. If the person whose freedom of movement has been limited has tuberculosis, the court shall continue the limitation for a period not to exceed one calendar year if it determines, by a preponderance of the evidence, that the limitation is reasonably necessary to prevent or limit the conveyance of tuberculosis to others. The court order shall specify the period of time the limitation is to be continued and shall provide for automatic termination of the order upon written determination by the State Health Director or local health director that the quarantine or isolation is no longer necessary to protect the public health. In addition, where the petitioner can prove by a preponderance of the evidence that quarantine or isolation was not or is no longer needed for protection of the public health, the person quarantined or isolated may move the trial court to reconsider its order extending quarantine or isolation before the time for the order otherwise expires and may seek immediate or expedited termination of the order. Before the expiration of an order limiting the freedom of movement of a person with tuberculosis, the State Health Director or local health director may move to continue the order for additional periods not to exceed one calendar year each. (1957, c. 1357, s. 1; 1983, c. 891, s. 2; 1987, c. 782, s. 15; 2002-179, s. 5; ratified 1st day of July, 2004)

19) § 130A-146. Transportation Of Bodies Of Persons Who Have Died of A Reportable Disease

No person shall transport in this State the remains of any person who has died of a disease declared by the Commission to be reported until the body has been encased in a manner as prescribed by rule by the Commission. Only persons who have complied with the rules of the Commission concerning the removal of dead bodies shall be issued a burial-transit permit. (1893, c. 214, s. 16; Rev., s. 4459; C.S., s. 7161; 1953, c. 675, s. 16; 1957, c. 1357, s. 1; 1973, c. 476, s. 128; 1983, c. 891, s. 2.)

20) § 130A-147. Rules of The Commission

For the protection of the public health, the Commission is authorized to adopt rules for the detection, control and prevention of communicable diseases. (1983, c. 891, s. 2.)

21) § 130A-440. (Applicable to children enrolling in the public schools for the first time beginning with the 2016-2017 school year) Health assessment required.

(a) Every parent, guardian, or person standing in loco parentis shall submit proof of a health assessment for each child in this State who is presented for admission into kindergarten or a higher grade in the public schools for the first time. The health assessment shall be made no more than 12 months prior to the date the child would have first been eligible for initial entry into the public

schools. Within 30 calendar days of a child's first day of attendance in the public schools, a health assessment transmittal form, developed pursuant to G.S. 130A-441, indicating that the child has received the health assessment required by this section, shall be presented to the school principal. The only health assessment transmittal form utilized by public schools shall be the form developed pursuant to G.S. 130A-441. A completed health assessment transmittal form shall be presented to the principal of the school by either (i) the parent, guardian, or person standing in loco parentis or (ii) the health care provider specified in G.S. 130A-440(c), if authorized in writing by the parent, guardian, or person standing in loco parentis. At the time of enrollment, the parent, guardian, or person standing in loco parentis shall be advised that a health assessment transmittal form is needed on or before the child's first day of attendance. If a health assessment transmittal form is not presented on or before the child's first day of attendance, the principal shall present a notice of deficiency to the parent, guardian, or person standing in loco parentis. The notice of deficiency shall include at least the following information: (i) the health assessment transmittal form must be submitted to the principal within 30 calendar days of the child's first day of attendance or the child will not be permitted to attend school until the form is submitted and (ii) an explanation for how the child may make up work missed in accordance with G.S. 115C-390.2(l). The parent, guardian, or person standing in loco parentis shall have 30 calendar days from the first day of attendance to present the required health assessment transmittal form for the child. Upon termination of 30 calendar days, the principal shall not permit the child to attend the school until the required health assessment transmittal form has been presented. A child shall not be suspended for absences accrued for failure to present the required health assessment transmittal form upon the termination of 30 calendar days, and the child shall be allowed to make up work missed in accordance with G.S. 115C-390.2(l). It shall be noted in the child's official school record when the health assessment transmittal form has been received.

(b) A health assessment shall include a medical history and physical examination with screening for vision and hearing and, if appropriate, testing for anemia and tuberculosis. Vision screening shall be conducted in accordance with G.S. 130A-440.1. The health assessment may also include dental screening and developmental screening for cognition, language, and motor function. The developmental screening of cognition and language abilities may be conducted in accordance with G.S. 115C-83.5(a).

(c) The health assessment shall be conducted by a physician licensed to practice medicine, a physician's assistant as defined in G.S. 90-18.1(a), a certified nurse practitioner, or a public health nurse meeting the Department's Standards for Early Periodic Screening, Diagnosis, and Treatment Screening.

(d) This Article shall not apply to children entering private church schools, schools of religious charter, or qualified nonpublic schools, regulated by Article 39 of Chapter 115C of the General Statutes.

(e) As used in this section, "parent, guardian, or person standing in loco parentis" means parent, legal guardian, legal custodian, and caregiver adult, as those terms are used in G.S. 115C-366. (1985 (Reg. Sess., 1986), c. 1017, s. 1; 1987, c. 114, s. 1; 1989, c. 727, s. 155; 1993, c. 124, s. 1; 1995, c. 123, s. 10; 2006-240, s. 1(b); 2012-142, s. 7A.1(h); 2015-222, s. 2.)

22) § 153A-225. Medical care of prisoners.

(a) Each unit that operates a local confinement facility shall develop a plan for providing medical care for prisoners in the facility. The plan:

- (1) Shall be designed to protect the health and welfare of the prisoners and to avoid the spread of contagious disease;
- (2) Shall provide for medical supervision of prisoners and emergency medical care for prisoners to the extent necessary for their health and welfare;
- (3) Shall provide for the detection, examination and treatment of prisoners who are infected with tuberculosis or venereal diseases; and
- (4) May utilize Medicaid coverage for inpatient hospitalization or for any other Medicaid services allowable for eligible prisoners, provided that the plan includes a reimbursement process which pays to the State the State portion of the costs, including the costs of the services provided and any administrative costs directly related to the services to be reimbursed, to the State's Medicaid program.

The unit shall develop the plan in consultation with appropriate local officials and organizations, including the sheriff, the county physician, the local or district health director, and the local medical society. The plan must be approved by the local or district health director after consultation with the area mental health, developmental disabilities, and substance abuse authority, if it is adequate to protect the health and welfare of the prisoners. Upon a determination that the plan is adequate to protect the health and welfare of the prisoners, the plan must be adopted by the governing body. As a part of its plan, each unit may establish fees of not more than twenty dollars (\$20.00) per incident for the provision of nonemergency medical care to prisoners and a fee of not more than ten dollars (\$10.00) for a 30-day supply or less of a prescription drug. In establishing fees pursuant to this section, each unit shall establish a procedure for waiving fees for indigent prisoners.

(b) If a prisoner in a local confinement facility dies, the medical examiner and the coroner shall be notified immediately. Within five days after the day of the death, the administrator of the facility shall make a written report to the local or district health director and to the Secretary of Health and Human Services. The report shall be made on forms developed and distributed by the Department of Health and Human Services.

(b1) Whenever a local confinement facility transfers a prisoner from that facility to another local confinement facility, the transferring facility shall provide the receiving facility with any health information or medical records the transferring facility has in its possession pertaining to the transferred prisoner.

- 3) If a person violates any provision of this section (including the requirements regarding G.S. 130-97 and 130-121), he is guilty of a Class 1 misdemeanor. (1967, c. 581, s. 2; 1973, c. 476, ss. 128, 138; c. 822, s. 1; 1973, c. 1140, s. 3; 1989, c. 727, s. 204; 1991, c. 237, s. 2; 1993, c. 539, s. 1062; 1994, Ex. Sess., c. 24, s. 14(c); 1995, c. 385, s. 1; 1997-443, s. 11A.112; 2003-392, s. 1; 2004-199, s. 46(a); 2011-145, s. 31.26(f); 2011-192, s. 7(n); 2013-387, s. 2; 2013-389, s. 1.)

B. North Carolina Administrative Code (Rules)

Day Care Rules - Section .0700 - Health and Other Standards For Center Staff

1) 10A NCAC 09 .0701 HEALTH STANDARDS FOR CHILD CARE PROVIDERS, SUBSTITUTE PROVIDERS, VOLUNTEERS, AND UNCOMPENSATED PROVIDERS

(a) Health and emergency information shall be obtained for staff members as specified in the chart below:

Required for:	Item Requirements:	Due Date:
Child care providers and uncompensated providers who are not substitute providers or volunteers as defined in 10A NCAC 09 .0102, including the director.	<p>Medical Report</p> <p>A statement signed by a health care professional that indicates that the person is emotionally and physically fit to care for children.</p>	<p>Within 60 days of employment.</p> <p>When submitted, the medical statement shall not be older than 12 months.</p>
All staff, including the director and individuals who volunteer more than once per week.	<p>Tuberculin (TB) Test or Screening</p> <p>The results indicating the individual is free of active tuberculosis shall be obtained within the 12 months prior to the date of employment.</p>	On or before first day of work.
Child care providers, including the director, uncompensated providers, substitute providers, and volunteers.	Emergency Information Form, including the name, address, and telephone number of the person to be contacted in case of an emergency, the responsible party's choice of health care professional, any chronic illness, any medication taken for that illness, and any other information that has a direct bearing on ensuring safe medical treatment for the individual.	<p>On or before the first day of work.</p> <p>The emergency information shall be updated as changes occur and at least annually.</p>
All staff, including the director.	<p>Health Questionnaire</p> <p>A statement signed by the staff member that indicates that the person is emotionally and physically fit to care for children.</p>	Annually following the initial medical statement.
Substitute providers and volunteers.	<p>Health Questionnaire</p> <p>A statement signed by the substitute provider or volunteer that indicates that the person is</p>	On or before first day of work and annually thereafter.

	emotionally and physically fit to care for children.	
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(b) The Division, or the director of the child care center, may request an evaluation of a staff member's emotional and physical fitness to care for children when there is reason to believe that there has been deterioration in the staff member's emotional or physical fitness to care for children. This request may be based upon factors such as observations by the director or center staff, reports of concern from family, reports from law enforcement or reports from medical personnel.

(c) A copy of the forms in the chart in Paragraph (a) of this Rule may be found on the Division's website at http://ncchildcare.nc.gov/providers/pv_provideforms.asp.

(d) Staff medical statements, proof of a tuberculosis test or screening, and completed health questionnaires shall be included in the staff member's individual personnel file in the center.

*History Note: Authority G.S. 110-85; 110-91(1),(8),(9); 143B-168.3;
Eff. January 1, 1986;
Amended Eff. July 1, 2010; July 1, 1998;
Readopted Eff. October 1, 2017.*

2) 10A NCAC 70E .1104 CRITERIA FOR THE FAMILY

(a) Foster parents shall be persons whose behaviors, circumstances, and health are conducive to the safety and well-being of children. Foster parents shall be selected on the basis of demonstrating strengths in the skill areas of Subparagraphs (1) through (12) of this Paragraph which permit them to undertake and perform the responsibilities of meeting the needs of children, in providing continuity of care, and in working with the supervising agency. Foster parents shall demonstrate skills in:

- (1) assessing individual and family strengths and needs and building on strengths and meeting needs;
- (2) using and developing effective communication;
- (3) identifying the strengths and needs of children placed in the home;
- (4) building on children's strengths and meeting the needs of children placed in the home;
- (5) developing partnerships with children placed in the home, parents or the guardians of the children placed in the home, the supervising agency and the community to develop and carry out plans for permanency;
- (6) helping children placed in the home develop skills to manage loss and skills to form attachments;
- (7) helping children placed in the home manage their behaviors;
- (8) helping children placed in the home maintain and develop relationships that will keep them connected to their pasts;
- (9) helping children placed in the home build on positive self-concept and positive family, cultural, and racial identity;
- (10) providing a safe and healthy environment for children placed in the home which keeps them free from harm;
- (11) assessing the ways in which providing family foster care or therapeutic foster care affects the family; and
- (12) making an informed decision regarding providing family foster care or therapeutic foster care.

(b) Age. A license may only be issued to persons 21 years of age and older.

(c) Health. The foster family shall be in good physical and mental health as evidenced by:

- (1) a medical examination completed by a licensed medical provider on each member of the foster home within the last 12 months prior to the initial licensing application date, and biennially thereafter;
- (2) documentation that each adult member of the household has had a TB skin test or chest x-ray prior to initial licensure unless contraindicated by a licensed medical provider. The foster parents' children are required to be tested only if one or more of the parent's tests positive for TB;
- (3) a medical history form completed on each member of the household at the time of the initial licensing application and on any person who subsequently becomes a member of the household;
- (4) no indication of alcohol abuse, drug abuse, or illegal drug use by a member of the foster family;
- (5) no indication that a member of the foster family is a perpetrator of domestic violence;
- (6) no indication that a member of the foster family has abused, neglected, or exploited a disabled adult;
- (7) no indication that a member of the foster family has been placed on the North Carolina Sex Offender and Public Protection Registry pursuant to Article 27A Part 2 of G.S. 14;
- (8) no indication that a member of the foster family has been placed on the Health Care Personnel Registry pursuant to G.S. 131E-256; and
- (9) no indication that a member of the foster family has been found to have abused or neglected a child or has been a respondent in a juvenile court proceeding that resulted in the removal of a child or has had child protective services involvement that resulted in the removal of a child.

(d) Education. Foster parent applicants shall have graduated from high school or received a GED (Graduate Equivalency Diploma) or shall have an ability to read and write as evidenced by their ability to administer medications as prescribed by a licensed medical provider, maintain medication administration logs and maintain progress notes.

(e) Required Applicants. Foster parent applicants who are married are presumed to be co-parents in the same household and both shall complete all licensing requirements. Adults 21 years of age or older, living in currently licensed or newly licensed foster homes who have responsibility for the care, supervision, or discipline of the foster child shall complete all licensing requirements. The supervising agency shall assess each adult's responsibility for the care, supervision, or discipline of the foster child.

History Note: Authority G.S. 131D-10.1; 131D-10.3; 131D-10.5; 143B-153; Eff. September 1, 2007; Amended Eff. November 1, 2009; Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. October 3, 2017.

Rules for the Licensing of Group Homes for the Developmentally Disabled

Subchapter 27G - Rules For Mental Health, Developmental Disabilities, And Substance Abuse Facilities And Services - Section .0100 - General Information

3) 10A NCAC 27G .0202 Personnel Requirements

- (a) All facilities shall have a written job description for the director and each staff position which:
- (1) specifies the minimum level of education, competency, work experience and other qualifications for the position;

- (2) specifies the duties and responsibilities of the position;
 - (3) is signed by the staff member and the supervisor; and
 - (4) is retained in the staff member's file.
- (b) All facilities shall ensure that the director, each staff member or any other person who provides care or services to clients on behalf of the facility:
- (1) is at least 18 years of age;
 - (2) is able to read, write, understand and follow directions;
 - (3) meets the minimum level of education, competency, work experience, skills and other qualifications for the position; and
 - (4) has no substantiated findings of abuse or neglect listed on the North Carolina Health Care Personnel Registry.
- (c) All facilities or services shall require that all applicants for employment disclose any criminal conviction. The impact of this information on a decision regarding employment shall be based upon the offense in relationship to the job for which the applicant is applying.
- (d) Staff of a facility or a service shall be currently licensed, registered or certified in accordance with applicable state laws for the services provided.
- (e) A file shall be maintained for each individual employee indicating the training, experience and other qualifications for the position, including verification of licensure, registration or certification.
- (f) Continuing education shall be documented.
- (g) Employee training programs shall be provided and, at a minimum, shall consist of the following:
- (1) general organizational orientation;
 - (2) training on client rights and confidentiality as delineated in 10A NCAC 27C, 27D, 27E, 27F and 10A NCAC 26B;
 - (3) training to meet the mh/dd/sa needs of the client as specified in the treatment/habilitation plan; and
 - (4) training in infectious diseases and blood borne pathogens.
- (h) Except as permitted under 10a NCAC 27G .5602(b) of this Subchapter, at least one staff member shall be available in the facility at all times when a client is present. That staff member shall be trained in basic first aid including seizure management, currently trained to provide cardiopulmonary resuscitation and trained in the Heimlich maneuver or other first aid techniques such as those provided by Red Cross, the American Heart Association or their equivalence for relieving airway obstruction.
- (i) The governing body shall develop and implement policies and procedures for identifying, reporting, investigating and controlling infectious and communicable diseases of personnel and clients.

*History Note: Authority G.S. 122C-26;
 Eff. May 1, 1996;
 Temporary Amendment Eff. January 3, 2001;
 Temporary Amendment Expired October 13, 2001;
 Temporary Amendment Eff. November 1, 2001;
 Amended Eff. April 1, 2003.*

Rules For The Licensing Of Nursing Homes - Section .2200 - General Standards Of Administration

4) 10A NCAC 13D .2209 INFECTION CONTROL

- (a) A facility shall establish and maintain an infection control program for the purpose of providing a safe, clean and comfortable environment and preventing the transmission of diseases and infection.
- (b) Under the infection control program, the facility shall decide what procedures, such as isolation techniques, are needed for individual patients, investigate episodes of infection and attempt to control and prevent infections in the facility.
- (c) The facility shall maintain records of infections and of the corrective actions taken.
- (d) The facility shall ensure communicable disease testing as required by 10A NCAC 41A, "Communicable Disease Control" which is incorporated by reference, including subsequent amendments. Copies of these Rules may be obtained at no charge by contacting the N.C. Department of Health and Human Services, Division of Public Health, Tuberculosis Control Branch, 1902 Mail Service Center, Raleigh, North Carolina 27699-1902. Screening shall be done upon admission of all patients being admitted from settings other than hospitals, nursing facilities or combination facilities. Staff shall be screened within seven days of the hire date. The facility shall ensure tuberculosis screening annually thereafter for patients and staff.
- (e) All cases of reportable disease as defined by 10A NCAC 41A "Communicable Disease Control" and outbreaks consisting of two or more linked cases of disease transmission shall be reported to the local health department.
- (f) The facility shall use isolation precautions for any patient deemed appropriate by its infection control program and as recommended by the following Centers for Disease Control guidelines, Management of Multidrug-Resistant Organisms In Healthcare Settings, 2006, <http://www.cdc.gov/ncidod/dhqp/pdf/ar/MDROGuideline2006.pdf> and 2007 Guideline for Isolation Precautions: Preventing Transmission of Infectious Agents in Healthcare Settings, <http://www.cdc.gov/hicpac/2007ip/2007isolationprecautions.html>.
- (g) The facility shall prohibit any employee with a communicable disease or infected skin lesion from direct contact with patients or their food, if direct contact is the mode of transmission of the disease.
- (h) The facility shall require all staff to use hand washing technique as indicated in the Centers for Disease Control, "Guideline for Hand Hygiene in Health-Care Settings, Recommendations of the Healthcare Infection Control Practices Advisory Committee and the HICPAC/SHEA/APIC/IDSA Hand Hygiene Task Force". This information can be accessed at <http://www.cdc.gov/mmwr/preview/mmwrhtml/rr5116a1.htm>.
- (i) All linen shall be handled, stored, processed and transported so as to prevent the spread of infection.

History Note: Authority G.S. 131E-104; 131E-113;

Eff. January 1, 1996;

Amended Eff. July 1, 2012;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. March 22, 2015.

***Rules For Adult Assisted Living Homes, Rest Homes
Subchapter 13F – Licensing Of Homes For The Aged And Infirm -
Section .0400 – Staff Qualifications***

5) 10A NCAC 13F .0406 TEST FOR TUBERCULOSIS

- (a) Upon employment or living in an adult care home, the administrator and all other staff and any live-in non-residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902.

(b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others.

*History Note: Authority G.S. 131D-2.16; 131D-4.5; 143B-165;
Eff. January 1, 1977;
Readopted Eff. October 31, 1977;
Temporary Amendment Eff. September 1, 2003; July 1, 2003;
Amended Eff. June 1, 2004.*

Section .0700 - Admission And Discharge

6) 10A NCAC 13F .0703 TUBERCULOSIS TEST, MEDICAL EXAMINATION AND IMMUNIZATIONS

- (A) UPON ADMISSION TO AN ADULT CARE HOME, EACH RESIDENT SHALL BE TESTED FOR TUBERCULOSIS DISEASE IN COMPLIANCE WITH THE CONTROL MEASURES ADOPTED BY THE COMMISSION FOR PUBLIC HEALTH AS SPECIFIED IN 10A NCAC 41A .0205 INCLUDING SUBSEQUENT AMENDMENTS AND EDITIONS. COPIES OF THE RULE ARE AVAILABLE AT NO CHARGE BY CONTACTING THE DEPARTMENT OF HEALTH AND HUMAN SERVICES, TUBERCULOSIS CONTROL PROGRAM, 1902 MAIL SERVICE CENTER, RALEIGH, NORTH CAROLINA 27699-1902.
- (B) EACH RESIDENT SHALL HAVE A MEDICAL EXAMINATION PRIOR TO ADMISSION TO THE FACILITY AND ANNUALLY THEREAFTER.
- (C) THE RESULTS OF THE COMPLETE EXAMINATION REQUIRED IN PARAGRAPH (B) OF THIS RULE ARE TO BE ENTERED ON THE FL-2, NORTH CAROLINA MEDICAID PROGRAM LONG TERM CARE SERVICES, OR MR-2, NORTH CAROLINA MEDICAID PROGRAM MENTAL RETARDATION SERVICES, WHICH SHALL COMPLY WITH THE FOLLOWING:
- (1) THE EXAMINING DATE RECORDED ON THE FL-2 OR MR-2 SHALL BE NO MORE THAN 90 DAYS PRIOR TO THE PERSON'S ADMISSION TO THE HOME.
 - (2) THE FL-2 OR MR-2 SHALL BE IN THE FACILITY BEFORE ADMISSION OR ACCOMPANY THE RESIDENT UPON ADMISSION AND BE REVIEWED BY THE FACILITY BEFORE ADMISSION EXCEPT FOR EMERGENCY ADMISSIONS.
 - (3) IN THE CASE OF AN EMERGENCY ADMISSION, THE MEDICAL EXAMINATION AND COMPLETION OF THE FL-2 OR MR-2 AS REQUIRED BY THIS RULE SHALL BE WITHIN 72 HOURS OF ADMISSION AS LONG AS CURRENT MEDICATION AND TREATMENT ORDERS ARE AVAILABLE UPON ADMISSION OR THERE HAS BEEN AN EMERGENCY MEDICAL EVALUATION, INCLUDING ANY ORDERS FOR MEDICATIONS AND TREATMENTS, UPON ADMISSION.
 - (4) IF THE INFORMATION ON THE FL-2 OR MR-2 IS NOT CLEAR OR IS INSUFFICIENT, THE FACILITY SHALL CONTACT THE PHYSICIAN FOR CLARIFICATION IN ORDER TO DETERMINE IF THE SERVICES OF THE FACILITY CAN MEET THE INDIVIDUAL'S NEEDS.
 - (5) THE COMPLETED FL-2 OR MR-2 SHALL BE FILED IN THE RESIDENT'S RECORD IN THE HOME.
 - (6) IF A RESIDENT HAS BEEN HOSPITALIZED, THE FACILITY SHALL HAVE A COMPLETED FL-2 OR MR-2 OR A TRANSFER FORM OR DISCHARGE

- SUMMARY WITH SIGNED PRESCRIBING PRACTITIONER ORDERS UPON THE RESIDENT'S RETURN TO THE FACILITY FROM THE HOSPITAL.
- (D) EACH RESIDENT SHALL BE IMMUNIZED AGAINST PNEUMOCOCCAL DISEASE AND ANNUALLY AGAINST INFLUENZA VIRUS ACCORDING TO G.S. 13D-9, EXCEPT AS OTHERWISE INDICATED IN THIS LAW.
- (E) THE FACILITY SHALL MAKE ARRANGEMENTS FOR ANY RESIDENT, WHO HAS BEEN AN INPATIENT OF A PSYCHIATRIC FACILITY WITHIN 12 MONTHS BEFORE ENTERING THE HOME AND WHO DOES NOT HAVE A CURRENT PLAN FOR PSYCHIATRIC CARE, TO BE EXAMINED BY A LOCAL PHYSICIAN OR A PHYSICIAN IN A MENTAL HEALTH CENTER WITHIN 30 DAYS AFTER ADMISSION AND TO HAVE A PLAN FOR PSYCHIATRIC FOLLOW-UP CARE WHEN INDICATED.

HISTORY NOTE: AUTHORITY G.S. 131D-2.16; 143B-165; TEMPORARY ADOPTION EFF. SEPTEMBER 1, 2003; Eff. June 1, 2004.

LICENSING OF FAMILY CARE HOMES - SECTION .0400 - STAFF QUALIFICATIONS

7) 10A NCAC 13G .0405 TEST FOR TUBERCULOSIS

- (a) Upon employment or living in a family care home, the administrator, all other staff and any live in non residents shall be tested for tuberculosis disease in compliance with control measures adopted by the Commission for Public Health as specified in 10A NCAC 41A .0205 including subsequent amendments and editions. Copies of the rule are available at no charge by contacting the Department of Health and Human Services. Tuberculosis Control Program, 1902 Mail Service Center, Raleigh, NC 27699-1902.
- (b) There shall be documentation on file in the home that the administrator, all other staff and any live-in non-residents are free of tuberculosis disease that poses a direct threat to the health or safety of others.

History Note: Authority G.S. 131D 2.16; 131D-4.5; 143B-165; Eff. January 1, 1977; Amended Eff. October 1, 1977; April 22, 1977; Readopted Eff. October 31, 1977; Amended Eff. December 1, 1993; April 1, 1984; Temporary Amendment Eff. September 1, 2003; Amended Eff. June 1, 2004.

8) 10A NCAC 13G .0907 RESPITE CARE

- (a) For the purposes of this Subchapter, respite care is defined as supervision, personal care and services provided for persons admitted to a family care home on a temporary basis for temporary caregiver relief, not to exceed 30 days.
- (b) Respite care is not required as a condition of licensure. However, respite care is subject to the requirements of this Subchapter except for Rules .0703, .0705, .0801, .0802 and .1201.
- (c) The number of respite care residents and family care home residents shall not exceed the facility's licensed bed capacity.
- (d) The respite care resident contract shall specify the rates for respite care services and accommodations, the date of admission to the facility and the proposed date of discharge from the facility. The contract shall be signed by the administrator or designee and the respite care resident or his responsible person and a copy given to the resident and responsible person.
- (e) Upon admission of a respite care resident into the facility, the facility shall assure that the resident has a current FL-2 and been tested for tuberculosis disease according to Rule .0702 of

this Subchapter and that there are current physician orders for any medications, treatments and special diets for inclusion in the respite care resident's record. The facility shall assure that the respite care resident's physician or prescribing practitioner is contacted for verification of orders if the orders are not signed and dated within seven calendar days prior to admission to the facility as a respite care resident or for clarification of orders if orders are not clear or complete.

(f) The facility shall complete an assessment which allows for the development of a short-term care plan prior to or upon admission to the facility with input from the resident or responsible person. The assessment shall address respite resident needs, including identifying information, hearing, vision, cognitive ability, functional limitations, continence, special procedures and treatments as ordered by physician, skin conditions, behavior and mood, oral and nutritional status and medication regimen. The facility may use the Resident Register or an equivalent as the assessment instrument. The care plan shall be signed and dated by the facility's administrator or designated representative and the respite care resident or responsible person.

(g) The respite care resident's record shall include a copy of the signed respite care contract; the FL-2; the assessment and care plan; documentation of a tuberculosis test according to Paragraph (e) of this Rule; documentation of any contacts (office, home or telephone) with the resident's physician or other licensed health professionals from outside the facility; physician orders; medication administration records; a statement, signed and dated by the resident or responsible person, indicating that information on the home as required in Rule .0704 of this Subchapter has been received; a written description of any acute changes in the resident's condition or any incidents or accidents resulting in injury to the respite care resident, and any action taken by the facility in response to the changes, incidents or accidents; and how the responsible person or his designated representative can be contacted in case of an emergency.

(h) The respite care resident's responsible person or his designated representative shall be contacted and informed of the need to remove the resident from the facility if one or more of the following conditions exists:

- (1) the resident's condition is such that he is a danger to himself or poses a direct threat to the health of others as documented by a physician; or
- (2) the safety of individuals in the home is threatened by the behavior of the resident as documented by the facility.

Documentation of the emergency discharge shall be on file in the facility.

*History Note: Authority G.S. 131D-2.16; 143B-165;
Temporary Adoption Eff. November 1, 2000;
Eff. July 18, 2002;
Temporary Amendment Eff. July 1, 2004;
Amended Eff. July 1, 2005;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public
interest Eff. February 16, 2019.*

Home Care Rules

9) 10A NCAC 13J .1003 PERSONNEL

(a) Written policies shall be established and implemented by the agency regarding infection control and exposure to communicable diseases consistent with Subchapter 19A of Title 15A, North Carolina Administrative Code. These policies shall include provisions for compliance with 29 CFR 1910 (Occupational Safety and Health Standards) which is incorporated by reference including subsequent amendments. Copies of Title 29 Part 1910 can be purchased from the Superintendent of Documents, U.S. Government Printing Office, P.O. Box 371954, Pittsburgh, PA 15250-7954 or by calling Washington, D.C. (202) 512-1800. The cost is twenty-one dollars (\$21.00) and may be purchased with a credit card.

(b) Hands-on care employees must have a baseline skin test for TB. Individuals who test positive must demonstrate noninfectious status prior to assignment in a client's home. Individuals who have previously tested positive to the TB skin test shall obtain a baseline and subsequent annual verification that they are free of TB symptoms. This verification shall be obtained from the local health department, a private physician or health nurse employed by the agency. The Tuberculosis Control Branch of the North Carolina Department of Health and Human Services, Division of Public Health, 1902 Mail Service Center, Raleigh, NC 27699-1902 shall provide, free of charge, guidelines for conducting verification and Form DHHS 3405 (Record of Tuberculosis Screening). Employees identified by agency risk assessment, to be at risk for exposure shall be subsequently tested at intervals prescribed by OSHA standards.

(c) The agency shall not hire any individual either directly or by contract who has a substantiated finding on the North Carolina Health Care Personnel Registry in accordance with G.S. 131E-256(a)(1).

(d) Written policies shall be established and implemented which include personnel record content, orientation and in-service education. Records on the subject of in-service education and attendance shall be maintained by the agency and retained as set out in Paragraph (f) of this Rule.

(e) Job descriptions for every position shall be established in writing which include qualifications and specific responsibilities. Individuals shall be assigned only to duties for which they are trained and competent to perform and when applicable for which they are licensed.

(f) Personnel records shall be established and maintained for each home care employee. When requested, the records shall be available on the agency premises for inspection by the Department. These records shall be maintained for at least one year after termination from agency employment. The records shall include the following:

- (1) an application or resume which lists education, training and previous employment that can be verified, including job title;
- (2) a job description with record of acknowledgment by the employee;
- (3) reference checks or verification of previous employment;
- (4) records of tuberculosis screening for employees for whom the test is necessary as described in Paragraph (a) of this Rule;
- (5) documentation of Hepatitis B immunization or declination for hands-on care employees in accordance with the agency's exposure control plan;
- (6) airborne and bloodborne pathogen training for hands on care employees, including annual updates, in compliance with 29 CFR 1910 and in accordance with the agency's exposure control plan;
- (7) performance evaluations according to agency policy and at least annually. These evaluations may be confidential pursuant to Rule .0905 of this Subchapter;
- (8) verification of employees' credentials as applicable; and
- (9) records of the verification of competencies by agency supervisory personnel of all skills required of home care services personnel to carry out client care tasks to which the employee is assigned. The method of verification shall be defined in agency policy.

(g) For in-home aides not listed on the nurse aide registry, personnel records shall include verification of core competencies by a registered nurse that includes the following core personal care skills for in-home aides hired after April 1, 2009:

- (1) Assisting with Mobility including ambulation, transfers and bed mobility;
- (2) Assisting with Bath/Shower;
- (3) Assisting with Toileting;
- (4) Assisting with Dressing;
- (5) Assisting with Eating; and
- (6) Assisting with continence needs.

History Note: Authority G.S. 131E-140;

Eff. July 1, 1992;
Amended Eff. February 1, 1996; June 1, 1994;
Temporary Amendment Eff. April 1, 2006;
Amended Eff. January 1, 2010; October 1, 2006;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public
interest Eff. June 25, 2016.

Hospice Rules

10) 10A NCAC 13K .0401 Hospice Licensing Rules - Personnel

(a) Written policies shall be established and implemented by the agency regarding infection control and exposure to communicable diseases consistent with 10A NCAC 41A. These policies and procedures shall include provisions for compliance with 29 CFR 1910 (Occupational Safety and Health Standards) which is incorporated by reference including subsequent amendments. Emphasis shall be placed on compliance with 29 CFR 1910.1030 (Airborne and Bloodborne Pathogens). Copies of Title 29 Part 1910 can be purchased from the Superintendent of Documents, U.S. Government Printing Office, P.O. Box 371954, Pittsburgh, PA 15250-7954 or by calling Washington, D.C. (202) 512-1800. The cost is twenty one dollars (\$21.00) and may be purchased with a credit card. Hands-on care employees must have a baseline skin test for tuberculosis. Individuals who test positive must demonstrate non-infectious status prior to assignment in a patient's home. Individuals who have previously tested positive to the tuberculosis skin test shall obtain a baseline and subsequent annual verification that they are free of tuberculosis symptoms. The verification shall be obtained from the local health department, a private physician or health nurse employed by the agency. The Tuberculosis Control Branch of the North Carolina Department of Health and Human Services, Division of Public Health, 1902 Mail Service Center, Raleigh, NC 27699-1902 will provide, free of charge guidelines for conducting verification and Form DEHNR 3405 (Record of Tuberculosis Screening). Employees identified by agency risk assessment to be at risk for exposure are required to be subsequently tested at intervals prescribed by OSHA standards.

(b) Written policies shall be established and implemented which include personnel record content, orientation, patient family volunteer training and in-service education. Records on the subject of in-service education and attendance shall be maintained by the agency and retained for at least one year.

(c) Job descriptions for every position, including volunteers involved in direct patient/family services, shall be established in writing which include qualifications and specific responsibilities. Individuals shall be assigned only to duties for which they are trained and competent to perform and when applicable for which they are properly licensed.

(d) Personnel records shall be established and maintained for all hospice staff, both paid and direct patient/family services volunteers. These records shall be maintained at least one year after termination from agency employment. When requested, the records shall be available on the agency premises for inspection by the Department. The records shall include:

- (1) an application or resume which lists education, training and previous employment that can be verified, including job title;
- (2) a job description with record of acknowledgment by the staff;
- (3) reference checks or verification of previous employment;
- (4) records of tuberculosis annual screening for those employees for whom the test is necessary as described in Paragraph (a) of this Rule;
- (5) documentation of Hepatitis B immunization or declination for hands on care staff;

- (6) airborne and blood borne pathogen training for hands on care staff, including annual updates, in compliance with 29 CFR 1910 and in accordance with the agency's exposure control plan;
- (7) performance evaluations according to agency policy and at least annually;
- (8) verification of staff credentials as applicable;
- (9) records of the verification of competencies by agency supervisory personnel of all skills required of hospice services personnel to carry out patient care tasks to which the staff is assigned. The method of verification shall be defined in agency policy.

*History Note: Authority G.S. 131E-202;
Eff. November 1, 1984;
Amended Eff. February 1, 1996; November 1, 1989.*

Jail Rules

Subchapter 14J – Jails, Local Confinement Facilities

Section .1000 - Health Care Of Inmates And Exercise

11) 10A NCAC 14J .1001 Medical Plan

- (a) A written medical plan shall be developed in compliance with G.S. 153A-225 and it shall be available for ready reference by jail personnel. The medical plan shall include a description of the health services available to inmates.
- (b) The written plan shall include policies and procedures that address the following areas:
 - (1) Health screening of inmates upon admission;
 - (2) Handling routine medical care;
 - (3) The handling of inmates with chronic illnesses or known communicable diseases or conditions;
 - (4) Administration, dispensing and control of prescription and non-prescription medications;
 - (5) Handling emergency medical problems, including but not limited to emergencies involving dental care, chemical dependency, pregnancy and mental health;
 - (6) Maintenance and confidentiality of medical records; and
 - (7) Privacy during medical examinations and conferences with qualified medical personnel.
- (c) Inmates must be provided an opportunity each day to communicate their health complaints to a health professional or to an officer. Qualified medical personnel shall be available to evaluate the medical needs of inmates. A written record shall be maintained of the request for medical care and the action taken.
- (d) Inmates shall not perform any medical functions in the jail.
- (e) The medical plan shall be reviewed annually.

*History Note: Authority G.S. 143B-153; 153A-221;
Eff. June 1, 1990;
Amended Eff. December 1, 1991.*

12) 10A NCAC 14J .1002 Health Screening Form

The health screening form completed upon admission by an officer shall be available to jail officers, and a copy of the form shall be kept in any medical file that is maintained for inmates. The form shall be reviewed for the presence of confidential information which can not be made available to jail officers.

*History Note: Authority G.S. 143B-153; 153A-221;
Eff. June 1, 1990;
Amended Eff. December 1, 1991.*

13) 10A NCAC 14J .1003 MEDICAL ISOLATION

Each jail shall separate inmates who require medical isolation from other inmates, either by housing them in a separate area of the jail or by transferring them to another facility.

*History Note: Authority G.S. 153A-221;
Eff. June 1, 1990;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest
Eff. January 5, 2016.*

**Administrative Codes – Communicable Disease Rules
Chapter 41 - Epidemiology Health - Subchapter 41a - Communicable Disease Control
Section .0100 - Reporting Of Communicable Diseases**

14) 10A NCAC 41A .0101 Reportable Diseases And Conditions

For a complete list of diseases that must be reported and time frames for reporting please see:

<http://reports.oah.state.nc.us/ncac/title%2010a%20-%20health%20and%20human%20services/chapter%2041%20-%20epidemiology%20health/subchapter%20a/10a%20ncac%2041a%20.0101.html>

15) 10A NCAC 41A .0102 Method Of Reporting

(a) When a report of a disease or condition is required to be made pursuant to G.S. 130A-135 through 139 and 10A NCAC 41A .0101, with the exception of laboratories, which shall proceed as in Subparagraph (d), the report shall be made to the local health director as follows:

- (1) For diseases and conditions required to be reported within 24 hours, the initial report shall be made by telephone, and the report required by Subparagraph (2) of this Paragraph shall be made within seven days.
- (2) In addition to the requirements of Subparagraph (1) of this Paragraph, the report shall be made on the communicable disease report card or in an electronic format provided by the Division of Public Health and shall include the name and address of the patient, the name and address of the parent or guardian if the patient is a minor, and epidemiologic information.
- (3) In addition to the requirements of Subparagraphs (1) and (2) of this Paragraph, forms or electronic formats provided by the Division of Public Health for collection of information necessary for disease control and documentation of clinical and epidemiologic information about the cases shall be completed and submitted for the following reportable diseases and conditions identified in 15A NCAC 19A .0101(a) acquired immune deficiency syndrome (AIDS); brucellosis; cholera; cryptosporidiosis; cyclosporiasis; E. coli 0157:H7 infection; ehrlichiosis; Haemophilus influenzae, invasive disease; Hemolytic-uremic syndrome/thrombotic thrombocytopenic purpura; hepatitis A; hepatitis B; hepatitis B carriage; hepatitis C; human immunodeficiency virus (HIV) confirmed; legionellosis; leptospirosis; Lyme disease; malaria; measles (rubeola); meningitis, pneumococcal; meningococcal disease; mumps; paralytic

poliomyelitis; psittacosis; Rocky Mountain spotted fever; rubella; rubella congenital syndrome; tetanus; toxic shock syndrome; trichinosis; tuberculosis; tularemia; typhoid; typhoid carriage (*Salmonella typhi*); vibrio infection (other than cholera); and whooping cough.

- (4) Communicable disease report cards, surveillance forms, and electronic formats are available from the Division of Public Health, 1915 Mail Service Center, Raleigh, North Carolina 27699-1915, and from local health departments.

(b) Notwithstanding the time frames established in 10A NCAC 41A .0101 a restaurant or other food or drink establishment shall report all outbreaks or suspected outbreaks of food borne illness in its customers or employees and all suspected cases of food borne disease or food borne condition in food-handlers at the establishment by telephone to the local health department within 24 hours in accordance with Subparagraph (a)(1) of this Rule. However, the establishment is not required to submit a report card or surveillance form pursuant to Subparagraphs (a)(2) and (a)(4) of this Rule.

(c) For the purposes of reporting by restaurants and other food or drink establishments pursuant to G.S.130A-138, the following diseases and conditions listed in 10A NCAC 41A .0101(a) shall be reported: anthrax; botulism; brucellosis; campylobacter infection; cholera; cryptosporidiosis; cyclosporiasis; *E. coli* 0157:H7 infection; hepatitis A; salmonellosis; shigellosis; streptococcal infection, Group A, invasive disease; trichinosis; tularemia; typhoid; typhoid carriage (*Salmonella typhi*); and vibrio infection (other than cholera).

(d) Laboratories required to report test results pursuant to G.S. 130A-139 and 10A NCAC 41A .0101(c) shall report as follows:

- (1) The results of the specified tests for syphilis, Chlamydia and gonorrhea shall be reported to the local health department by the first and fifteenth of each month. Reports of the results of the specified tests for gonorrhea, Chlamydia and syphilis shall include the specimen collection date, the patient's age, race, and sex, and the submitting physician's name, address, and telephone numbers.
- (2) Positive darkfield examinations for syphilis, all reactive prenatal and delivery STS titers, all reactive STS titers on infants less than one year old and STS titers of 1:8 and above shall be reported within 24 hours by telephone to the HIV/STD Prevention and Care Branch at (919) 733-7301, or the HIV/STD Prevention and Care Branch Regional Office where the laboratory is located.
- (3) With the exception of positive laboratory tests for human immunodeficiency virus, positive laboratory tests as defined in G.S. 130A-139(1) and 10A NCAC 41A .0101(c) shall be reported to the Division of Public Health electronically, by mail, by secure telefax or by telephone within the time periods specified for each reportable disease or condition in 10A NCAC 41A .0101(a). Confirmed positive laboratory tests for human immunodeficiency virus as defined in 10A NCAC 41A .0101(b) shall be reported to the HIV/STD Prevention and Care Branch within seven days of obtaining reportable test results. Reports shall include as much of the following information as the laboratory possesses: the specific name of the test performed; the source of the specimen; the collection date(s); the patient's name, age, race, sex, address, and county; and the submitting physician's name, address, and telephone number.

History Note: Authority G.S. 130A-134; 130A-135; 130A-138; 130A-139; 130A-141; Temporary Rule Eff. February 1, 1988, for a period of 180 days to expire on July 29, 1988; Eff. March 1, 1988; Amended Eff. October 1, 1994; February 3, 1992; December 1, 1991; May 1, 1991;

Temporary Amendment Eff. December 16, 1994, for a period of 180 days or until the permanent rule becomes effective, whichever is sooner; Temporary Amendment Expired June 16, 1995; Amended Eff. April 1, 2003; August 1, 1998.

16) 10A NCAC 41A .0103 Duties Of Local Health Director: Report Communicable Diseases

(a) Upon receipt of a report of a communicable disease or condition pursuant to 10A NCAC 41A .0101, the local health director shall:

- (1) immediately investigate the circumstances surrounding the occurrence of the disease or condition to determine the authenticity of the report and the identity of all persons for whom control measures are required. This investigation shall include the collection and submission for laboratory examination of specimens necessary to assist in the diagnosis and indicate the duration of control measures;
- (2) determine what control measures have been given and ensure that proper control measures as provided in 10A NCAC 41A .0201 have been given and are being complied with;
- (3) forward the report as follows:
 - (A) The local health director shall forward all authenticated reports made pursuant to G.S. 130A-135 to 137 of syphilis, chancroid, granuloma inguinale, and lymphogranuloma venereum within seven days to the regional office of the Division of Public Health. In addition, the local health director shall telephone reports of all cases of primary, secondary, and early latent (under one year's duration) syphilis to the regional office of the HIV/STD Prevention and Care Branch within 24 hours of diagnosis at the health department or report by a physician.
 - (B) The local health director shall telephone all laboratory reports of reactive syphilis serologies to the regional office of the Division of Public Health within 24 hours of receipt if the person tested is pregnant. This shall also be done for all other persons tested unless the dilution is less than 1:8 and the person is known to be over 25 years of age or has been previously treated. In addition, the written reports shall be sent to the regional office of the Division of Public Health within seven days.
 - (C) Except as provided in (a)(3)(A) and (B) of this Rule, a local health director who receives a report pursuant to 10A NCAC 41A .0102 regarding a person residing in that jurisdiction shall forward the authenticated report to the Division of Public Health within seven days.
 - (D) Except as provided in (a)(3)(A) and (B) of this Rule, a local health director who receives a report pursuant to 10A NCAC 41A .0102 regarding a person who resides in another jurisdiction in North Carolina shall forward the report to the local health director of that jurisdiction within 24 hours. A duplicate report card marked "copy" shall be forwarded to the Division of Epidemiology within seven days.
 - (E) A local health director who receives a report pursuant to 10A NCAC 41A .0102 regarding a person who resided outside of North Carolina at the time of onset of the illness shall forward the report to the Division of Public Health within 24 hours.

(b) If an outbreak exists, the local health director shall submit to the Division of Public Health within 30 days a written report of the investigation, its findings, and the actions taken to control the outbreak and prevent a recurrence.

(c) Whenever an outbreak of a disease or condition occurs which is not required to be reported by 10A NCAC 41A .0101 but which represents a significant threat to the public health, the local health director shall give appropriate control measures consistent with 10A NCAC 41A .0200, and inform the Division of Public Health of the circumstances of the outbreak within seven days.

*History Note: Authority G.S. 130A-141; 130A-144;
Temporary Rule Eff. February 1, 1988, for a period of 180 days to expire on July 29, 1988;
Eff. March 1, 1988;
Amended Eff. April 1, 2003; December 1, 1991; September 1, 1990.*

17) 10A NCAC 41A .0104 Release Of Communicable Disease Records: Research Purposes

(a) A person may request, for bona fide research purposes, the release of records which pertain to a communicable disease or communicable condition and which identify individuals. The request shall be in writing and shall contain the following information:

- (1) Name of organization requesting the data;
- (2) Names of principal investigators;
- (3) Name of project;
- (4) Purpose of project;
- (5) Description of the proposed use of the data, including protocols for contacting patients, relatives, and service providers;
- (6) Descriptions of measures to protect the security of the data;
- (7) An assurance that the data will not be used for purposes other than those described in the protocol;
- (8) An assurance that the data will be properly disposed of upon completion of the project; and
- (9) An assurance that the results of the project will be provided to the custodian of the records.

(b) The request for release of the records shall be granted or denied in writing based upon the following considerations:

- (1) Whether the objectives of the project require patient identifying information;
- (2) Whether the objective of the project can be reached with the use of the data;
- (3) Whether the project has a reasonable chance of answering a legitimate research question;
- (4) Whether the project might jeopardize the ability of the Epidemiology Division to obtain reports and information regarding communicable diseases and communicable conditions;
- (5) Whether the patient's right to privacy would be adequately protected.

*History Note: Temporary Rule Eff. February 1, 1988, for a period of 180 days to expire on July 29, 1988;
Authority G.S. 130A-143(9);
Eff. March 1, 1988;
Amended Eff. September 1, 1991.*

Control Measures

Section .0200 - Control Measures For Communicable Diseases

18) 10A NCAC 41A .0201 CONTROL MEASURES - GENERAL

(A) EXCEPT AS PROVIDED IN RULES OF THIS SECTION, THE RECOMMENDATIONS AND GUIDELINES FOR TESTING, DIAGNOSIS, TREATMENT, FOLLOW-UP, AND PREVENTION OF TRANSMISSION FOR EACH DISEASE AND CONDITION SPECIFIED BY THE AMERICAN PUBLIC HEALTH ASSOCIATION IN ITS PUBLICATION, CONTROL OF COMMUNICABLE DISEASES MANUAL SHALL BE THE REQUIRED CONTROL MEASURES. CONTROL OF COMMUNICABLE DISEASES MANUAL IS HEREBY INCORPORATED BY REFERENCE INCLUDING SUBSEQUENT AMENDMENTS AND EDITIONS. GUIDELINES AND RECOMMENDED ACTIONS PUBLISHED BY THE CENTERS FOR DISEASE CONTROL AND PREVENTION SHALL SUPERCEDE THOSE CONTAINED IN THE CONTROL OF COMMUNICABLE DISEASE MANUAL AND ARE LIKEWISE INCORPORATED BY REFERENCE, INCLUDING SUBSEQUENT AMENDMENTS AND EDITIONS. COPIES OF THE CONTROL OF COMMUNICABLE DISEASES MANUAL MAY BE PURCHASED FROM THE AMERICAN PUBLIC HEALTH ASSOCIATION, PUBLICATION SALES DEPARTMENT, POST OFFICE BOX 753, WALDORA, MD 20604 FOR A COST OF TWENTY-TWO DOLLARS (\$22.00) EACH PLUS FIVE DOLLARS (\$5.00) SHIPPING AND HANDLING. COPIES OF CENTERS FOR DISEASE CONTROL AND PREVENTION GUIDELINES CONTAINED IN THE MORBIDITY AND MORTALITY WEEKLY REPORT MAY BE PURCHASED FROM THE SUPERINTENDENT OF DOCUMENTS, U.S. GOVERNMENT PRINTING OFFICE, WASHINGTON, DC 20402 FOR A TOTAL COST OF THREE DOLLARS AND FIFTY CENTS (\$3.50) EACH. COPIES OF BOTH PUBLICATIONS ARE AVAILABLE FOR INSPECTION IN THE DIVISION OF PUBLIC HEALTH, 1915 MAIL SERVICE CENTER, RALEIGH, NORTH CAROLINA 27699-1915.

(B) IN INTERPRETING AND IMPLEMENTING THE SPECIFIC CONTROL MEASURES ADOPTED IN PARAGRAPH (A) OF THIS RULE, AND IN DEVISING CONTROL MEASURES FOR OUTBREAKS DESIGNATED BY THE STATE HEALTH DIRECTOR AND FOR COMMUNICABLE DISEASES AND CONDITIONS FOR WHICH A SPECIFIC CONTROL MEASURE IS NOT PROVIDED BY THIS RULE, THE FOLLOWING PRINCIPLES SHALL BE USED:

(1) CONTROL MEASURES SHALL BE THOSE WHICH CAN REASONABLY BE EXPECTED TO DECREASE THE RISK OF TRANSMISSION AND WHICH ARE CONSISTENT WITH RECENT SCIENTIFIC AND PUBLIC HEALTH INFORMATION;

(2) FOR DISEASES OR CONDITIONS TRANSMITTED BY THE AIRBORNE ROUTE, THE CONTROL MEASURES SHALL REQUIRE PHYSICAL ISOLATION FOR THE DURATION OF INFECTIVITY;

(3) FOR DISEASES OR CONDITIONS TRANSMITTED BY THE FECAL-ORAL ROUTE, THE CONTROL MEASURES SHALL REQUIRE EXCLUSIONS FROM SITUATIONS IN WHICH TRANSMISSION CAN BE REASONABLY EXPECTED TO OCCUR, SUCH AS WORK AS A PAID OR VOLUNTARY FOOD HANDLER OR ATTENDANCE OR WORK IN A DAY CARE CENTER FOR THE DURATION OF INFECTIVITY;

(4) FOR DISEASES OR CONDITIONS TRANSMITTED BY SEXUAL OR THE BLOOD-BORNE ROUTE, CONTROL MEASURES SHALL REQUIRE PROHIBITION OF DONATION OF BLOOD, TISSUE, ORGANS, OR SEMEN, NEEDLE-SHARING, AND SEXUAL CONTACT IN A MANNER LIKELY TO RESULT IN TRANSMISSION FOR THE DURATION OF INFECTIVITY.

(C) PERSONS WITH CONGENITAL RUBELLA SYNDROME, TUBERCULOSIS, AND CARRIERS OF SALMONELLA TYPHI AND HEPATITIS B WHO CHANGE RESIDENCE TO A DIFFERENT LOCAL HEALTH DEPARTMENT JURISDICTION SHALL NOTIFY THE LOCAL HEALTH DIRECTOR IN BOTH JURISDICTIONS.

(D) ISOLATION AND QUARANTINE ORDERS FOR COMMUNICABLE DISEASES AND COMMUNICABLE CONDITIONS FOR WHICH CONTROL MEASURES HAVE BEEN ESTABLISHED SHALL REQUIRE COMPLIANCE WITH APPLICABLE CONTROL MEASURES AND SHALL STATE PENALTIES FOR FAILURE TO COMPLY. THESE ISOLATION AND

QUARANTINE ORDERS MAY BE NO MORE RESTRICTIVE THAN THE APPLICABLE CONTROL MEASURES.

(E) AN INDIVIDUAL ENROLLED IN AN EPIDEMIOLOGIC OR CLINICAL STUDY SHALL NOT BE REQUIRED TO MEET THE PROVISIONS OF 10A NCAC 41A .0201 - .0209 WHICH CONFLICT WITH THE STUDY PROTOCOL IF:

(1) THE PROTOCOL IS APPROVED FOR THIS PURPOSE BY THE STATE HEALTH DIRECTOR BECAUSE OF THE SCIENTIFIC AND PUBLIC HEALTH VALUE OF THE STUDY, AND

(2) THE INDIVIDUAL FULLY PARTICIPATES IN AND COMPLETES THE STUDY.

(F) A DETERMINATION OF SIGNIFICANT RISK OF TRANSMISSION UNDER THIS SUBCHAPTER SHALL BE MADE ONLY AFTER CONSIDERATION OF THE FOLLOWING FACTORS, IF KNOWN:

(1) THE TYPE OF BODY FLUID OR TISSUE;

(2) THE VOLUME OF BODY FLUID OR TISSUE;

(3) THE CONCENTRATION OF PATHOGEN;

(4) THE VIRULENCE OF THE PATHOGEN; AND

(5) THE TYPE OF EXPOSURE, RANGING FROM INTACT SKIN TO NON-INTACT SKIN, OR MUCOUS MEMBRANE.

(G) THE TERM "HOUSEHOLD CONTACTS" AS USED IN THIS SUBCHAPTER MEANS ANY PERSON RESIDING IN THE SAME DOMICILE AS THE INFECTED PERSON.

HISTORY NOTE: AUTHORITY G.S. 130A-135; 130A-144;

TEMPORARY RULE EFF. FEBRUARY 1, 1988, FOR A PERIOD OF 180 DAYS TO EXPIRE ON JULY 29, 1988;

EFF. MARCH 1, 1988;

AMENDED EFF. FEBRUARY 1, 1990; NOVEMBER 1, 1989; AUGUST 1, 1988;

RECODIFIED PARAGRAPHS (D), (E) TO RULE .0202; PARAGRAPH (I) TO RULE .0203 EFF. JUNE 11, 1991;

AMENDED EFF. APRIL 1, 2003; OCTOBER 1, 1992; DECEMBER 1, 1991; AUGUST 1, 1998;

EMERGENCY AMENDMENT EFF. JANUARY 24, 2005;

EMERGENCY AMENDMENT EXPIRED ON APRIL 16, 2005.

19) 10A NCAC 41A .0202 CONTROL MEASURES – HIV

The following are the control measures for the Acquired Immune Deficiency Syndrome (AIDS) and Human Immunodeficiency Virus (HIV) infection:

(1) Infected persons shall:

(a) refrain from sexual intercourse unless condoms are used; exercise caution when using condoms due to possible condom failure;

(b) not share needles or syringes, or any other drug-related equipment, paraphernalia, or works that may be contaminated with blood through previous use;

(c) not donate or sell blood, plasma, platelets, other blood products, semen, ova, tissues, organs, or breast milk;

(d) have a skin test for tuberculosis;

(e) notify future sexual intercourse partners of the infection; if the time of initial infection is known, notify persons who have been sexual intercourse and needle partners since the date of infection; and, if the date of initial infection is unknown, notify persons who have been sexual intercourse and needle partners for the previous year.

(2) The attending physician shall:

(a) give the control measures in Item (1) of this Rule to infected patients, in accordance with 10A NCAC 41A .0210;

- (b) If the attending physician knows the identity of the spouse of an HIV-infected patient and has not, with the consent of the infected patient, notified and counseled the spouse, the physician shall list the spouse on a form provided by the Division of Epidemiology and shall mail the form to the Division; the Division shall undertake to counsel the spouse; the attending physician's responsibility to notify exposed and potentially exposed persons is satisfied by fulfilling the requirements of Sub-Items (2)(a) and (b) of this Rule;
 - (c) advise infected persons concerning clean-up of blood and other body fluids;
 - (d) advise infected persons concerning the risk of perinatal transmission and transmission by breastfeeding.
- (3) The attending physician of a child who is infected with HIV and who may pose a significant risk of transmission in the school or day care setting because of open, oozing wounds or because of behavioral abnormalities such as biting shall notify the local health director. The local health director shall consult with the attending physician and investigate the circumstances.
- (a) If the child is in school or scheduled for admission and the local health director determines that there may be a significant risk of transmission, the local health director shall consult with an interdisciplinary committee, which shall include school personnel, a medical expert, and the child's parent or guardian to assist in the investigation and determination of risk. The local health director shall notify the superintendent or private school director of the need to appoint such an interdisciplinary committee.
 - (i) If the superintendent or private school director establishes such a committee within three days of notification, the local health director shall consult with this committee.
 - (ii) If the superintendent or private school director does not establish such a committee within three days of notification, the local health director shall establish such a committee.
 - (b) If the child is in school or scheduled for admission and the local health director determines, after consultation with the committee, that a significant risk of transmission exists, the local health director shall:
 - (i) notify the parents;
 - (ii) notify the committee;
 - (iii) assist the committee in determining whether an adjustment can be made to the student's school program to eliminate significant risks of transmission;
 - (iv) determine if an alternative educational setting is necessary to protect the public health ;
 - (v) instruct the superintendent or private school director concerning protective measures to be implemented in the alternative educational setting developed by appropriate school personnel; and
 - (vi) consult with the superintendent or private school director to determine which school personnel directly involved with the child need to be notified of the HIV infection in order to prevent transmission and ensure that these persons are instructed regarding the necessity for protecting confidentiality.
 - (c) If the child is in day care and the local health director determines that there is a significant risk of transmission, the local health director shall notify the parents that the child must be placed in an alternate child care setting that eliminates the significant risk of transmission.
- (4) When health care workers or other persons have a needle stick or nonsexual non-intact skin or mucous membrane exposure to blood or body fluids that, if the source were

infected with HIV, would pose a significant risk of HIV transmission, the following shall apply:

- (a) When the source person is known:
 - (i) The attending physician or occupational health care provider responsible for the exposed person, if other than the attending physician of the person whose blood or body fluids is the source of the exposure, shall notify the attending physician of the source that an exposure has occurred. The attending physician of the source person shall discuss the exposure with the source and shall test the source for HIV infection unless the source is already known to be infected. The attending physician of the exposed person shall be notified of the infection status of the source.
 - (ii) The attending physician of the exposed person shall inform the exposed person about the infection status of the source, offer testing for HIV infection as soon as possible after exposure and at reasonable intervals up to one year to determine whether transmission occurred, and, if the source person was HIV infected, give the exposed person the control measures listed in Sub-Items (1)(a) through (c) of this Rule. The attending physician of the exposed person shall instruct the exposed person regarding the necessity for protecting confidentiality.
 - (b) When the source person is unknown, the attending physician of the exposed persons shall inform the exposed person of the risk of transmission and offer testing for HIV infection as soon as possible after exposure and at reasonable intervals up to one year to determine whether transmission occurred.
 - (c) A health care facility may release the name of the attending physician of a source person upon request of the attending physician of an exposed person.
- (5) The attending physician shall notify the local health director when the physician, in good faith, has reasonable cause to suspect a patient infected with HIV is not following or cannot follow control measures and is thereby causing a significant risk of transmission. Any other person may notify the local health director when the person, in good faith, has reasonable cause to suspect a person infected with HIV is not following control measures and is thereby causing a significant risk of transmission.
 - (6) When the local health director is notified pursuant to Item (5) of this Rule, of a person who is mentally ill or mentally retarded, the local health director shall confer with the attending mental health physician or mental health authority and the physician, if any, who notified the local health director to develop a plan to prevent transmission.
 - (7) The Director of Health Services of the North Carolina Department of Correction and the prison facility administrator shall be notified when any person confined in a state prison is determined to be infected with HIV. If the prison facility administrator, in consultation with the Director of Health Services, determines that a confined HIV infected person is not following or cannot follow prescribed control measures, thereby presenting a significant risk of HIV transmission, the administrator and the Director shall develop and implement jointly a plan to prevent transmission, including making recommendations to the unit housing classification committee.
 - (8) The local health director shall ensure that the health plan for local jails include education of jail staff and prisoners about HIV, how it is transmitted, and how to avoid acquiring or transmitting this infection.
 - (9) Local health departments shall provide testing for HIV infection with pre- and post-test counseling at no charge to the patient. Third party payers may be billed for HIV counseling and testing when such services are provided and the patient provides written consent.
 - (10) Counseling for HIV testing shall include risk assessment, risk reduction guidelines, referrals for medical and psychosocial services, and, when the person tested is found to be infected with HIV, control measures. Pre-test counseling may be done in a group or

- individually, as long as each individual is provided the opportunity to ask questions in private. Post-test counseling must be individualized.
- (11) A local health department or the Department may release information regarding an infected person pursuant to G.S. 130A-143(3) only when the local health department or the Department has provided direct medical care to the infected person and refers the person to or consults with the health care provider to whom the information is released.
 - (12) Notwithstanding Rule .0201(d) of this Section, a local or state health director may require, as a part of an isolation order issued in accordance with G.S. 130A-145, compliance with a plan to assist the individual to comply with control measures. The plan shall be designed to meet the specific needs of the individual and may include one or more of the following available and appropriate services:
 - (a) substance abuse counseling and treatment;
 - (b) mental health counseling and treatment; and
 - (c) education and counseling sessions about HIV, HIV transmission, and behavior change required to prevent transmission.
 - (13) The Division of Epidemiology shall conduct a partner notification program to assist in the notification and counseling of partners of HIV infected persons. All partner identifying information obtained as a part of the partner notification program shall be destroyed within two years.
 - (14) Every pregnant woman shall be given HIV pre-test counseling, as described in 15A NCAC 19A .0202(10), by her attending physician as early in the pregnancy as possible. At the time this counseling is provided, and after informed consent is obtained, the attending physician shall test the pregnant woman for HIV infection, unless the pregnant woman refuses the HIV test.

History Note: Authority G.S. 130A-133; 130A-135; 130A-144; 130A-145; 130A-148(h); Temporary Rule Eff. February 1, 1988, for a period of 180 days to expire on July 29, 1988; Eff. March 1, 1988; Amended Eff. February 1, 1990; November 1, 1989; June 1, 1989; Temporary Amendment Eff. January 7, 1991 for a period of 180 days to expire on July 6, 1991; Amended Eff. May 1, 1991; Recodified from 15A NCAC 19A .0201 (d) and (e) Eff. June 11, 1991; Amended Eff. August 1, 1995; October 1, 1994; January 4, 1994; October 1, 1992; Temporary Amendment Eff. June 1, 2001; Temporary Amendment Eff. February 18, 2002; Amended Eff. April 1, 2003.

20) 10A NCAC 41A .0205 CONTROL MEASURES – TUBERCULOSIS

- (a) The local health director shall investigate all cases of tuberculosis disease and their contacts in accordance with recommendations and guidelines published by the Centers for Disease Control and Prevention which are hereby incorporated by reference including subsequent amendments and editions. The recommendations and guidelines are the required control measures for tuberculosis, except as otherwise provided in this Rule. A copy of the recommendations and guidelines is available by contacting the Division of Public Health, 1931 Mail Service Center, Raleigh, North Carolina 27699-1931 or by accessing the Centers for Disease Control and Prevention website at <http://www.cdc.gov/tb>.
- (b) The following persons shall have a tuberculin skin test (TST) or Interferon Gamma Release Assay (IGRA) administered in accordance with recommendations and guidelines published by the Centers for Disease Control and Prevention:

(1) Household and other high priority contacts of active cases of pulmonary and laryngeal tuberculosis. For purposes of this Rule, a high priority contact is defined in accordance with Centers for Disease Control and Prevention guidelines. If the contact's initial skin or IGRA test is negative, and the case is confirmed by culture, a repeat skin or IGRA test shall be performed 8 to 10 weeks after the exposure has ended;

(2) Persons reasonably suspected of having tuberculosis disease;

(3) Inmates in the custody of the Department of Public Safety, Division of Adult Correction upon incarceration, and annually thereafter;

(4) Persons with HIV infection or AIDS.

(c) The following persons shall be tested using a two-step skin test method or a single IGRA test, administered in accordance with recommendations and guidelines published by the Centers for Disease Control and Prevention:

(1) Staff with direct inmate contact in the Department of Public Safety, Division of Adult Correction upon employment;

(2) Staff of licensed nursing homes or adult care homes upon employment;

(3) Residents upon admission to licensed nursing homes or adult care homes. If the individual is being admitted directly from another hospital, licensed nursing home or adult care home in North Carolina and there is documentation of a two-step skin test or a single IGRA test, the individual does not need to be retested;

(4) Staff in adult day care centers providing care for persons with HIV infection or AIDS upon employment.

(d) Except as provided in the last sentence of Subparagraph (c)(3) of this Rule, persons listed in Paragraph (c) of this rule shall be required only to have a single TST or IGRA in the following situations:

(1) If the person has ever had a two-step skin test; or

(2) If the person has had a single skin test within the last twelve months.

(e) Persons with a positive tuberculin skin test or IGRA shall be evaluated by an interview to screen for symptoms and a chest x-ray if they do not have a documented chest x-ray that was performed on the date of the positive test or later.

(f) Treatment and follow-up for tuberculosis infection or disease shall be in accordance with the recommendations and guidelines from the Centers for Disease Control and Prevention.

(g) Persons with active tuberculosis disease shall complete a standard multi-drug regimen, and shall be managed using Directly Observed Therapy (DOT), which is the actual observation of medication ingestion by a health care worker (HCW).

If a standard multi-drug regimen cannot be used, the attending physician shall consult with the state Tuberculosis Medical Director or designee on the treatment plan.

(h) Persons with suspected or known active pulmonary or laryngeal tuberculosis who have sputum smears positive for acid fast bacilli shall be considered infectious and shall be managed using airborne precautions including respiratory isolation or isolation in their home with no new persons exposed. These individuals are considered noninfectious and use of airborne precautions, precautions including respiratory isolation or isolation in their home may be discontinued when:

(1) Sputum specimen results meet Centers for Disease Control and Prevention criteria for discontinuation of respiratory isolation;

(2) They have two consecutive sputum smears collected at least eight hours apart which are negative;

(3) It has been at least seven days since the last positive sputum smear; and

(4) They have been compliant on tuberculosis medications to which the organism is susceptible and there is evidence of clinical response to tuberculosis treatment.

(i) Persons with suspected or known active pulmonary or laryngeal tuberculosis who are initially sputum smear negative require respiratory isolation until they have been started on

tuberculosis treatment to which the organism is susceptible and there is evidence of clinical response to treatment.

History Note: Authority G.S. 130A-135; 130A-144;
Eff. March 1, 1992;
Amended Eff. April 1, 2006; April 1, 2003; August 1, 1998; October 1, 1994;
Temporary Amendment Eff. August 1, 2011;
Amended Eff. July 1, 2012.

21) 10A NCAC 41A .0206 **INFECTION PREVENTION – HEALTH CARE SETTINGS**

(a) The following definitions apply throughout this Rule:

(1) "Health care organization" means a hospital; clinic; physician, dentist, podiatrist, optometrist, or chiropractic office; home care agency; nursing home; local health department; community health center; mental health facility; hospice; ambulatory surgical facility; urgent care center; emergency room; Emergency Medical Service (EMS) agency; pharmacies where a health practitioner offers clinical services; or any other organization that provides clinical care.

(2) "Invasive procedure" means entry into tissues, cavities, or organs or repair of traumatic injuries. The term includes the use of needles to puncture skin, vaginal and cesarean deliveries, surgery, and dental procedures during which bleeding occurs or the potential for bleeding exists.

(3) "Non-contiguous" means not physically connected.

(b) In order to prevent transmission of HIV, hepatitis B, hepatitis C and other bloodborne pathogens each health care organization that performs invasive procedures shall implement a written infection control policy. The health care organization shall ensure that health care workers in its employ or who have staff privileges are trained in the principles of infection control and the practices required by the policy; require and monitor compliance with the policy; and update the policy as needed to prevent transmission of HIV, hepatitis B, hepatitis C and other bloodborne pathogens. The health care organization shall designate one on-site staff member for each noncontiguous facility to direct these activities. The designated staff member in each health care facility shall complete a course in infection control approved by the Department. The Department shall approve a course that addresses:

- (1) Epidemiologic principles of infectious disease;
- (2) Principles and practice of asepsis;
- (3) Sterilization, disinfection, and sanitation;
- (4) Universal blood and body fluid precautions;
- (5) Safe injection practices;
- (6) Engineering controls to reduce the risk of sharp injuries;

(7) Disposal of sharps; and

(8) Techniques that reduce the risk of sharp injuries to health care workers.

(c) The infection control policy required by this Rule shall address the following components that are necessary to prevent transmission of HIV, hepatitis B, hepatitis C and other bloodborne pathogens:

(1) Sterilization and disinfection, including a schedule for maintenance and microbiologic monitoring of equipment; the policy shall require documentation of maintenance and monitoring;

(2) Sanitation of rooms and equipment, including cleaning procedures, agents, and schedules;

(3) Accessibility of infection control devices and supplies; and

(4) Procedures to be followed in implementing 10A NCAC 41A .0202(4) and .0203(b)(4) when a health care provider or a patient has an exposure to blood or other body fluids of another person in a manner that poses a significant risk of transmission of HIV or hepatitis B.

(d) Health care workers and emergency responders shall, with all patients, follow Centers for Disease Control and Prevention Guidelines on blood and body fluid precautions incorporated by reference in 10A NCAC 41A .0201.

(e) Health care workers who have exudative lesions or weeping dermatitis shall refrain from handling patient care equipment and devices used in performing invasive procedures and from all direct patient care that involves the potential for contact of the patient, equipment, or devices with the lesion or dermatitis until the condition resolves.

(f) All equipment used to puncture skin, mucous membranes, or other tissues in medical, dental, or other settings must be disposed of in accordance with 15A NCAC 13B .1200 after use or sterilized prior to reuse.

History Note: Authority G.S. 130A 144; 130A 145; 130A-147;

Eff. October 1, 1992;

Amended Eff. January 1, 2010; December 1, 2003; July 1, 1994; January 4, 1994.

22) 10A NCAC 41A .0209 LABORATORY TESTING

All laboratories shall do the following:

- (1) When *Neisseria meningitidis* is isolated from a normally sterile site, test the organism for specific serogroup or send the isolate to the State Laboratory of Public Health for serogrouping;
- (2) When a stool culture is requested on a specimen from a person with bloody diarrhea, culture the stool for shiga-toxin producing *Escherichia coli* or send the specimen to the State Laboratory of Public Health;
- (3) When *Haemophilus influenzae* is isolated, test the organism for specific serogroup or send the isolate to the State Laboratory of Public Health for serogrouping; and
- (4) When *Mycobacterium tuberculosis* complex is isolated, test the organism for specific restriction fragment length polymorphism (RFLP) or send the isolate, or a subculture of the isolate, to the State Laboratory of Public Health for genotyping.

History Note: Authority G.S. 130A-139;

Eff. October 1, 1994;

Temporary Amendment Eff. February 18, 2002;

Amended Eff. April 1, 2004; April 1, 2003.

23) 10A NCAC 41A .0210 Duties Of Attending Physicians

Immediately upon making a diagnosis of or reasonably suspecting a communicable disease or communicable condition for which control measures are provided in Rule .0201, .0202 or .0203 of this Section, the attending physician shall instruct the patient and any other person specified in those control measures to carry out those control measures and shall give sufficiently detailed instructions for proper compliance, or the physician shall request the local health director to give such instruction. When making the initial telephone report for diseases and conditions required to be reported within 24 hours, the physician shall inform the local health director of the control measures given.

*History Note: Filed as a Temporary Rule Eff. February 1, 1988, for a period of 180 days to expire on July 29, 1988;
 Authority G.S. 130A-144;
 Eff. March 1, 1988;
 Recodified from 15A NCAC 19A .0202 Eff. June 11, 1991.*

24) 10A NCAC 41A .0211 Duties Of Other Persons

- (a) The local health director may reveal the identity and diagnosis of a person with a reportable communicable disease or communicable condition or other communicable disease or communicable condition which represents a significant threat to the public health

to those persons specified in Paragraph (b) when disclosure is necessary to prevent transmission in the facility or establishment for which they are responsible. The local health director shall ensure that all persons so notified are instructed regarding the necessity for protecting confidentiality.

(b) The following persons shall require that any person about whom they are notified pursuant to Paragraph (a) comply with control measures given by the local health director to prevent transmission in the facility or establishment:

- (1) the principal of any private or public school;
- (2) employers;
- (3) superintendents or directors of all public or private institutions, hospitals, or jails; and
- (4) operators of a child day care center, child day care home, or other child care providers.

(c) The provisions of Paragraphs (a) and (b) shall not apply with regard to gonorrhea, syphilis, chancroid, granuloma inguinale, lymphogranuloma venereum, Chlamydia, non-gonococcal urethritis, AIDS, and HIV infection. However, persons may be notified with regard to these diseases and conditions in accordance with 10A NCAC 41A .0201, .0202 or .0203 of this Section.

History Note: Filed as a Temporary Rule Eff. February 1, 1988, for a period of 180 days to expire on July 29, 1988; Authority G.S. 130A-143; 130A-144; Eff. March 1, 1988; Amended Eff. June 1, 1989; Recodified from 15A NCAC 19A .0203 Eff. June 11, 1991.

25) 10A NCAC 41A .0907 Release Of Information

The Department shall release information contained in the Biological Agents Registry only by order of the State Health Director upon a finding that the release is necessary for the conduct of a communicable disease investigation or for the investigation of a release, theft or loss of a biological agent.

History Note: Authority G.S. 130A-149; Temporary Adoption Eff. January 10, 2002; Eff. April 1, 2003.

Laboratory Rules - Subchapter 42B - Laboratory Sections

26) 10A NCAC 42B .0105 Microbiology

(a) This laboratory isolates and identifies anaerobic organisms and serves as a reference laboratory for confirmation of further identification of anaerobic bacteria.

(b) The laboratory examines fecal specimens for enteric pathogens from symptomatic patients, typhoid carriers, and contacts of such individuals. Environmental samples, such as food and water from aquariums or turtle bowls are examined if they are implicated as vehicles of infection. This laboratory is the designated serotyping center for the state of all isolates of salmonella and shigella for confirmation and surveillance purposes.

(c) This laboratory isolates and identifies pathogenic fungi from body tissues and fluids and serves as a reference laboratory for confirmation or further identification of fungi.

(d) This laboratory examines fecal and other specimens from symptomatic patients for the eggs, cysts, and larvae of the intestinal parasitic worms and protozoa. Blood smears are examined for parasitic blood diseases, such as malaria. Reference specimens or prepared stained slides from preserved material, biopsy material and tissue aspirates for tissue parasites are also accepted. Identification of arthropods is made.

- (e) This laboratory accepts a wide variety of bacteria which have been isolated by hospital or other laboratories, which are unusual, difficult to identify, fastidious, or infrequently encountered, thereby serving as a reference laboratory for other laboratories.
- (f) Sputa and specimens from other sources are examined for mycobacteria, including MYCOBACTERIUM TUBERCULOSIS and all isolates are tested for drug susceptibility using the drugs most commonly used for treating tuberculosis.
- (g) This laboratory may examine, upon request of an authorized sender of specimens, a variety of other specimens as the public health may require.

*History Note: Authority G.S. 130A-88;
Eff. October 1, 1985*

Local Standards - Section .0200 - Standards For Local Health Departments

27) 10A NCAC 46 .0201 MANDATED SERVICES

The following is a list of mandated services required to be provided in every county of this state. The local health department shall provide or ensure the provision of these services in accordance with the rules in this Section:

- (1) Adult Health;
- (2) Home Health;
- (3) Dental Public Health;
- (4) Food, Lodging and Institutional Sanitation;
- (5) Individual On-Site Water Supply;
- (6) Sanitary Sewage Collection, Treatment and Disposal;
- (7) Communicable Disease Control;
- (8) Vital Records Registration;
- (9) Maternal Health;
- (10) Child Health;
- (11) Family Planning;
- (12) Public Health Laboratory Support.

*History Note: Authority G.S. 130A-9;
Eff. July 1, 1984;
Transferred and Recodified from 10 NCAC 12 .0227 Eff. April 4, 1990;
Amended Eff. July 1, 2015;
Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. January 5, 2016.*

28) 10A NCAC 46 .0214 Communicable Disease Control

(a) A local health department shall provide services and perform activities for the control of communicable disease within the jurisdiction of the local health department. A local health department shall establish, implement, and maintain written policies which shall include a description of the procedures for communicable disease control services and activities provided by the local health department which shall include:

- (1) General Communicable Disease Control:
 - (A) Reporting communicable diseases as required by law. Additionally, cases of vaccine-preventable diseases shall be reported to the designated division program representative within 24 hours of receipt of the report.
 - (B) Investigating any outbreaks of a reportable communicable disease within the jurisdiction of the local health department to determine the cause of the outbreak

and to ensure that appropriate steps are taken to arrest the outbreak and prevent its recurrence.

- (C) Investigating each case of a communicable disease for which there is a surveillance form supplied by the Department. Forms shall be completed and submitted to the Department.
 - (D) Distributing communicable disease report cards with instructions for submission to all pediatricians, internists, and family or general practitioners practicing within the jurisdiction of the local health department.
- (2) Tuberculosis Control:
- (A) Tuberculosis diagnostic and follow-up services for cases, contacts, and suspects which include:
 - (i) Medical and epidemiological history;
 - (ii) Assessment of blood pressure, weight, urinalysis, if indicated, and visual acuity and color discrimination, if indicated;
 - (iii) Special investigations, such as Mantoux skin test, chest x-ray, mycobacteriology, and other investigations as indicated.
 - (B) Tuberculosis treatment services which include:
 - (i) Provision of anti-tuberculosis drugs as medically prescribed;
 - (ii) Monthly monitoring of intake and for adverse side effects of anti-tuberculosis drugs by office visit, home visit, or telephone;
 - (iii) Coordination and communication with private medical providers.
- (3) Immunization:
- (A) Providing resources to ensure that all children within the jurisdiction of the local health department receive all vaccines required by law within the time frames established by law.
 - (B) Providing vaccines in clinics, with at least one each month accessible to working parents.
 - (C) Enforcing the immunization law pertaining to day-care facilities, including submitting the immunization records audit form.
 - (D) Assisting local school officials in enforcing the immunization law pertaining to public and private schools (k-12).
 - (E) Ensuring accountability for all doses of vaccine provided by the Division.
- (4) Venereal Disease Control:
- (A) Diagnostic testing and examination services for syphilis and gonorrhea shall be available each weekday;
 - (B) Treatment services, both therapeutic and preventive, for reportable venereal disease shall be available each weekday;
 - (C) Counseling and education designed to influence disease intervention and prevention behaviors, particularly that designed to enlist patient cooperation in referring sex partners for examination and treatment, shall be available each weekday;
 - (D) Follow-up and referral of persons with positive venereal disease I laboratory tests shall be available each weekday.

(b) A local health department shall establish, implement, and maintain written policies for the provision of communicable disease control education services to the community, health care personnel, and patients. The services shall include provision of clinic schedules, information on communicable disease reporting, and other communicable disease control information to local medical organizations, veterinarians, animal control officers, health care providers, and the media, as appropriate.

*History Note: Authority G.S. 130A-9; Eff. October 1, 1984;
Transferred and Recodified from 10 NCAC 12 .0240 Eff. April 4, 1990;
Amended Eff. September 1, 1990.*

Pharmacy Rules - Section .2400 - Dispensing In Health Department

29) 21 NCAC 46 .2401 Medication In Health Departments

A registered nurse employed by a local health department may dispense prescription drugs or devices under the following conditions:

- (1) Drugs or devices may be dispensed only to health department patients;
- (2) No drugs or devices may be dispensed except at health department clinics;
- (3) The health department shall secure the services of a pharmacist-manager who shall be responsible for developing and supervising a system of control and accountability of all drugs dispensed from the health department;
- (4) Only the general categories of drugs or devices listed in Rule .2403 may be dispensed by a health department registered nurse;
- (5) All drugs or devices dispensed pursuant to G.S. 90-85.34A and these rules shall be packaged in suitable safety-closure containers, where appropriate, and shall be properly labeled (including necessary auxiliary labels) so as to provide information necessary for use and all other information required by state and federal law;
- (6) A suitable and perpetual record of drugs or devices dispensed shall be maintained in the health department. The pharmacist-manager shall verify the accuracy of the records at least weekly, and where health department personnel dispense to 30 or more patients in a 24-hour period per dispensing site, the pharmacist-manager shall verify the accuracy of the records within 24 hours after dispensing occurs;
- (7) The duties of the pharmacist-manager set out in Paragraphs (1) through (6) in this Rule may be delegated to a pharmacist licensed by the Board. The pharmacist-manager shall remain personally responsible for compliance with all statutes, rules, and regulations governing the practice of pharmacy and dispensing of drugs.

History Note: Authority G.S. 90-85.6; 90-85.34A
Eff. March 1, 1987; Amended Eff. May 1, 1989.

30) 21 NCAC 46 .2402 Training Of Health Department Nurses

(a) No registered nurse may dispense drugs or devices or perform any duties pursuant to G.S. 90-85.34A prior to satisfactory completion of training acceptable to the Board. The Board may require registered nurses to complete additional training regarding substantive changes in the law governing labeling and packaging of prescription drugs and devices.

(b) Proposed curricula for initial training for registered nurses secured by health departments must be submitted to the Board for its approval no later than 60 days prior to the date training is to commence. No registered nurses may be enrolled in any such proposed training course until written Board approval is obtained. Initial training must include, but need not be limited to, instruction in labeling and packaging of prescription drugs and devices.

(c) Written proposals shall be sent to the Board's offices, and shall include the following information:

- (1) description of topics or courses to be covered;
- (2) instructor for each topic or course, and his or her qualifications and credentials;
- (3) anticipated duration of each topic or course.

History Note: Authority G.S. 90-85.6; 90-85.34A;

Eff. March 1, 1987; Amended Eff. May 1, 1989.

31) 21 NCAC 46 .2403 DRUGS AND DEVICES TO BE DISPENSED

(a) Pursuant to the provisions of G.S. 90-85.34A(a)(3), prescription drugs and devices included in the following general categories may be dispensed by registered nurses in local health department clinics when prescribed for the indicated conditions:

- (1) Anti-tuberculosis drugs, as recommended by the North Carolina Department of Health and Human Services in the North Carolina Tuberculosis Policy Manual (available at www.ncdohhs.gov), when used for the treatment and control of tuberculosis;
- (2) Anti-infective agents used in the control of sexually-transmitted diseases as recommended by the United States Centers for Disease Control in the Sexually Transmitted Diseases Treatment Guidelines (available at www.cdc.gov);
- (3) Natural or synthetic hormones and contraceptive devices when used for the prevention of pregnancy;
- (4) Topical preparations for the treatment of lice, scabies, impetigo, diaper rash, vaginitis, and related skin conditions;
- (5) Vitamin and mineral supplements;
- (6) Opioid antagonists prescribed pursuant to G.S. 90-12.7;
- (7) Epinephrine auto-injectors prescribed pursuant to G.S. 115C-375.2A; and
- (8) Over-the-counter nicotine replacement therapies.

(b) Regardless of the provisions set out in this Rule, no drug defined as a controlled substance by the United States Controlled Substances Act, 21 U.S. Code 801 through 904, or regulations enacted pursuant to that Act, 21 CFR 1300 through 1308, or by the North Carolina Controlled Substances Act, G.S. 90-86 through 90-113.8, may be dispensed by registered nurses pursuant to G.S. 90-85.34A.

*History Note: Authority G.S. 90-12.7; 90-85.6; 90-85.34A; 115C-375.2A;
Eff. March 1, 1987;*

Amended Eff. September 1, 2016; January 1, 2015; August 1, 2014; May 1, 1989;

Pursuant to G.S. 150B-21.3A, rule is necessary without substantive public interest Eff. October 3, 2017;

Amended Eff. March 1, 2019.

C. Quick Reference for Tuberculin Skin Testing Requirements:

1. Tuberculin Skin Testing (TST) or IGRA (Interferon Gamma Release Assays) testing is **required** by communicable disease/TB rules for:

- **household and other close contacts** of active cases of pulmonary and laryngeal tuberculosis
By: 10 A NCAC 41A .0205
Frequency: at the time of exposure and 3 months post exposure
- persons reasonably **suspected of having tuberculosis disease**
By: 10 A NCAC 41A .0205
Frequency: when suspected
- **inmates in the custody of the Department of Corrections**
By: 10 A NCAC 41A .0205; DOC policy
Frequency: upon incarceration and annually
- **Department of Correction employees with direct inmate contact**
By: 10A NCAC 41A .0205; OSHA; DOC policy
Frequency: upon employment
- **patients in long term care facilities**
By: 10A NCAC 41A .0205; 10A NCAC 13D .2202 &.2209
Frequency: upon admission (two-step for TST or IGRA) & by risk assessment (DFS regulations require an annual screening which can be accomplished by a verbal elicitation of symptoms)
- **long term care facility employees**
By: 10A NCAC 41A .0205; 10A NCAC 13D .2202 & .2209; OSHA
Frequency: upon employment (two-step for TST or IGRA) & by risk assessment (DFS regulations require an annual screening which can be accomplished by a verbal elicitation of symptoms)
- **employees of adult day care centers providing care for persons with HIV infection or AIDS**
By: 10A NCAC 41A .0205
Frequency: upon employment (two-step for TST or IGRA) & by risk assessment
- **individuals with HIV infection or AIDS**
By: 10A NCAC 41A .0202 and 15A NCAC 19A .0205
Frequency: when diagnosed with HIV

2. Tuberculin Skin Testing (TST) may be required by agency rules or OSHA; if OSHA guidelines apply or annual testing is being done by policy, a two-step test or IGRA should be done at the time of hire

- **hospital employees**
By: OSHA
Frequency: upon employment
- **operating room employees**
By: OSHA
Frequency: upon employment
- **autopsy room employees**
By: OSHA
Frequency: upon employment
- **mycobacteriology laboratory employees**
By: OSHA
Frequency: upon employment
- **employees of ambulatory facilities that perform high hazard procedures on suspected or active tuberculosis patients**
By: OSHA
Frequency: upon employment
- **emergency medical personnel with direct patient contact**
By: OSHA
Frequency: upon employment
- **hospice employees with direct patient contact**

By: OSHA; 10A NCAC 13K .0401

Frequency: upon employment

- **home health care employees with direct patient contact**

By: OSHA; 10 NCAC 13J .1003

Frequency: upon employment

- **dental health employees in hospital or correctional care facilities**

By: OSHA

Frequency: upon employment

- **homeless shelter employees**

By: OSHA

Frequency: upon employment

- **drug treatment center employees**

By: OSHA

Frequency: upon employment

- **child day care center employees, substitutes and volunteers**

By: 10A NCAC 09 .0701& .0702

Frequency: questionnaire/risk assessment upon employment

- **subsidized non-licensed child care homes**

By: 10A NCAC 109 .0810

Frequency: upon approval

- **foster families**

By: 10A NCAC 70E .0402

Frequency: upon licensing

- **employees & residents of adult assisted living homes, & rest homes**

Frequency: upon admission or hire

By: 10A NCAC 13F .0406, & .0703

- **employees & residents of family care homes**

Frequency: upon admission or hire

By: 10A NCAC 13G .0405, & .0907

- **employees & residents of group homes for the developmentally disabled**

Frequency: determined by the governing body of the facility

By: 10A NCAC 27G .0202(i), which is interpreted by the licensing agency to mean a TST/IGRA is required

- **foreign-born college students arriving** from Africa, Asia, Caribbean, Latin America, Mexico, South America or Pacific Islands

By: American College Health Association (ACHA)

Frequency: upon college entry

- **college students in health occupations curriculums**

By: ACHA

Frequency: upon college entry & as required by practice setting

- **health check participants with higher risk for developing disease**

By: Medicaid Policy- see N.C Medicaid Special Bulletin April 2004

Frequency: upon presenting for health care

3. Medical offices or settings that do not fall into one of the above categories should conduct periodic risk assessments (see infection control chapter). Policies for TST/IGRA surveillance of workers should be based on the risk assessment and the likelihood of providing care to persons with TB disease.