/* The PENNSYLVANIA ADMINISTRATIVE CODE deals with long-term nursing facilities; insurance; education; workplace policies; reporting; and communicable diseases. */

5.10A. Acquired Immune Deficiency Syndrome (AIDS).
(a) A school entity shall provide instruction about Acquired Immune Deficiency Syndrome (AIDS) and related issues to its students at least once in the elementary grades, at least once in the middle/junior high school grades and at least once in the senior high school grades. This instruction shall be included in the curriculum in the health course and shall be presented in a series of systematic lessons covering the content outlined in subsection (c).
(b) The appropriate time in the school year shall be determined by each school district individually.
(c) Educational materials and instruction shall be determined by the local school district and be appropriate to the age group being taught. The program of instruction shall include, but need not be limited to, information about the nature of the disease, the lack of a cure, the ways the disease is transmitted and how infection can be prevented. The school district may omit instruction in the elementary grades on the transmission of the disease through sexual activity. Programs discussing the transmission of AIDS through sexual activity shall stress that abstinence from sexual activity is the only completely reliable means of preventing the sexual transmission of AIDS. The program shall stress that avoidance of illegal drug use is the only completely reliable means of preventing transmission of AIDS through shared drug paraphernalia.
(d) A school district shall excuse a pupil from AIDS instruction when this instruction conflicts with the religious beliefs or moral principles of the pupil or a parent or guardian of the pupil. A school district shall require written requests for excusals. Prior to the commencement of instruction, a school district shall publicize that detailed curriculum outlines and curricular materials used in conjunction with the instruction shall be available to parents and guardians during normal school hours or at teacher/parent conferences. Curricular materials, where practical, shall be made available by the school district for home instruction use by a parent or guardian of a student excused from the district's program of AIDS instruction.

5.13. Educational planning and assessment.
(a) Once every 5 years, school districts and area vocational-technical schools shall submit to the Department a LRP according to criteria established by the Secretary for the plan itself and

the planning process. Once the LRP has been submitted to the Department, changes to it submitted by a representative of the school entity shall have the prior approval of the school entity's board of directors.

(1) The development of the plan shall include, but not be limited to, the participation of administrators, school personnel, teachers, students, parents of school age children and members of the community.

(2) The LRP shall include a scheduling plan which will permit a student's participation in an area vocational technical school program and be able to meet mandated graduation requirements under 5.5 (relating to graduation requirements). When appropriate for the purpose of graduation, this plan should utilize 5.12 (relating to exceptions).

(3) The LRP and the curriculum it contains shall be available for public inspection at the district's central office.

(b) School districts may participate in the Educational Quality Assessment program. The Department will provide an opportunity for the school districts to participate at least once every 5 years.

(c) The Department will be responsible for coordinating the scheduling of Educational Quality Assessment participation and LRP submission dates.

(d) The LRP shall include evidence that each of the Goals of Quality Education and their learning objectives are addressed in the planned courses required and the planned courses offered by the school entity for all students.

(e) A separate planned course need not be taken for every goal. Multiple goals may be integrated in a single planned course. Each learning objective cited in this section shall be included in planned courses to be taken by all students at least once at the elementary, once at the junior/middle and once at the senior high school levels.

(f) The following are the Goals of Quality Education. The learning objectives are presented as subparagraphs under the goals with which they are typically associated. They may be linked to other appropriate goals.

(1) Communication skills. Quality education shall help every student acquire communication skills of understanding, speaking, listening, reading and writing. Objectives are:

(i) Comprehension of oral, written and nonverbal communication.

(ii) Composition of oral and written communication.

(iii) Interpretation of and facility with language patterns.

(iv) Comprehension and appreciation of literature and arts.

(v) Use of information sources and research techniques.

(2) Mathematics. Quality education shall help every student acquire knowledge, appreciation, and skills in mathematics.

Objectives are:
(i) Knowledge of numeration and computation.
(ii) Knowledge of geometry and measurement.
(iii) Knowledge of computer literacy and data management.
(iv) Development of reasoning, problem solving, and creativity.
(v) Knowledge of mathematical life skills and applications.
(3) Science and technology. Quality education shall help every student acquire the knowledge, understanding, and appreciation of science and technology. Objectives are:
(i) Knowledge of basic scientific concepts and processes.
(ii) Understanding of technological applications of scientific principles.
(iii) Appreciation of interaction of science, technology, and society.
(iv) Opportunity for inquiry and hands-on activity in science and technology.
(v) Understanding and use of scientific methodology.
(4) Citizenship. Quality education shall help every student learn the history of the United States understand its systems of government and economics, and acquire the values and attitudes necessary for responsible citizenship. Objectives are:
(i) Knowledge of histories: local, State, national and global.
(ii) Understanding of systems of government and law.
(iii) Understanding of systems of economics.
(iv) Knowledge of individual rights and responsibilities.
(v) Knowledge of the participatory nature of the democratic system.
(5) Arts and the humanities. Quality education shall help every student acquire knowledge, appreciation and skills in the arts and the humanities. Objectives are:
(i) Comprehension of principles and concepts in art, music, craftsmanship, other discrete arts, and the humanities.
(ii) Understanding of the influence of literature, philosophy, and tradition in shaping our heritage.
(iii) Development of analytic and performing skills in the arts and the humanities.
(iv) Application of objective and aesthetic criteria to decision-making.
(v) Participation in intellectual and creative experiences in the arts and humanities.
(6) Analytical thinking. Quality education shall help every student develop analytical thinking. Objectives are:
(i) Development of information management skills.
(ii) Development of logical thinking skills.
(iii) Development of problem solving skills.
(iv) Development of decision making skills.
(v) Family living. Quality education shall help every student

acquire the knowledge, skills and attitudes necessary for successful personal and family living. Objectives are:
(i) Development of personal and family relationships.
(ii) Selection, management, and maintenance of personal and family resources.
(iii) Understanding of economics of family life.
(iv) Development of consumer skills.
(8) Work. Quality education shall help every student acquire the knowledge, skills, and attitudes necessary to become a self-supporting member of society. Objectives are:
(i) Development of career awareness.
(ii) Development of personal career planning skills.
(iii) Development of job seeking, job getting, and job keeping skills.
(iv) Development of entry level occupational skills.
(v) Development of an awareness of the dignity of work.
(vi) Development of current labor market skills to foster economic development.
(9) Health. Quality education shall help every student acquire knowledge and develop practices necessary to maintain physical and emotional well-being. Objectives are:
(i) Development of personal and physical health.
(ii) Knowledge of community health, disease prevention and control including knowledge from instruction about Acquired Immune Deficiency Syndrome (AIDS), as required by 5.10a (relating to Acquired Immune Deficiency Syndrome (AIDS)).
(iii) Knowledge of human growth, development, and good nutrition.
(iv) Awareness of the dangers of tobacco, alcohol, and other drugs.
(v) Knowledge of safety and first aid skills.
(vi) Development of family and consumer health.
(10) Environment. Quality education shall help every student acquire the knowledge and attitudes necessary to maintain the quality of life in a balanced environment. Objectives are:
(i) Knowledge of natural and human resources.
(ii) Understanding of geographic environments: local, regional, global.
(iii) Knowledge of interrelationships and interdependence of natural and human systems.
(iv) Development of personal environmental attitudes and values.
(v) Development of environmental problem solving and management skills.
(vi) Knowledge of and appropriate uses of energy.
(11) Self-esteem. Quality education shall help every student develop
self-understanding and a feeling of self-worth. Objectives are:

(i) Understanding of personal strengths and limitations.
(ii) Recognition of one's personal abilities, interests and accomplishments.
(iii) Awareness of one's personal beliefs and opinions.
(iv) Development of self-confidence.
(v) Development of personal adaptability to change.
(12) Understanding others. Quality education shall help every student acquire knowledge of different cultures and an appreciation of the equal worth and rights of all people to include the active roles and contributions of women, minority racial and ethnic groups. Objectives are:
(i) Knowledge of cultural similarity and diversity.
(ii) Knowledge of individual similarity and diversity.
(iii) Development of interpersonal relationship skills.
(iv) Understanding of human interdependence.
(v) Knowledge of roles and contributions of racial and ethnic groups and women.

Ch. 7 MISCELLANEOUS PROVISIONS
Subchapter FF. AIDS WORK PLACE POLICY
Sec.
7.431. Overall AIDS work place policy.
7.432. Detailed provisions of the AIDS work place policy.
7.433. Agency AIDS policies.

7.431. Overall AIDS work place policy.
It is the policy of this administration to provide a concerned and nondiscriminatory environment for individuals with AIDS or HIV infection. A person with AIDS or HIV infection is to be treated with respect and dignity and not to be denied government service due to him. State employees and persons served by the Commonwealth will not be discriminated against on the basis of their AIDS or HIV status. Specific aspects of this policy related to State employment are set forth in this subchapter.

7.432. Detailed provisions of the AIDS work place policy.
(a) Individuals and State employees with AIDS or HIV infection, or those perceived to have these conditions, may not be discriminated against with regard to appointment, transfer, promotion or other employment action. The Pennsylvania Human Relations Act (43 P. 5. 951-962.2) prohibits the discrimination, as does section 504 of the Rehabilitation Act of 1973 (29 U.S.C.A. 794), the Civil Rights Restoration Act of 1987 (Pub. L. No. 100-259) (102 Stat. 28) and recent court decisions.
(b) No current or prospective State employee may be required to receive an AIDS or HIV antibody test as a condition of employment.

(c) State employees with AIDS or HIV infection shall continue in their current jobs and work assignments as long as their health permits. If an employee is unable physically to carry out his job duties, the employee shall be afforded the same considerations as another employee whose illness prevents him from performing job duties.
(d) Because of the episodic nature of the secondary illnesses which afflict persons with AIDS, employees may request reasonable accommodations which will allow them to continue to work with their handicap. These requests should be honored to the extent practicable. State employees with AIDS or HIV infection who request a transfer because of their medical condition should have these transfers considered, consistent with agency needs.
(e) Managers and supervisors should be given a point of contact within their agency where they can obtain further information on AIDS-related situations which arise in their work units.
(f) Agencies will provide ongoing education and information to employees on AIDS and HIV in order to increase knowledge about the disease. Effective education should result in better services to the public and should be ongoing to reinforce earlier efforts and to reflect new information.
(g) Federal guidelines for protection against exposure to blood and blood by-products should be adopted by Commonwealth agencies. These guidelines are issued by the United States Public Health Service, Centers for Disease Control (CDC). Agencies are to insure that staff who have the potential to be exposed to blood or blood by-products follow specific CDC guidelines, which are available from the Department of Health.
(h) State employees wanting more information on AIDS should contact their personnel office or other official designated as responsible for handling AIDS questions. Additional information can be obtained from the Department of Health hotline, local State Health Centers and local AIDS support groups.
(i) State employees wanting an AIDS or HIV antibody test should be referred to the Department of Health's testing centers. If a test is desired because of a documented incident in the work place, the test can be conducted during paid work hours and costs will be reimbursed by the Commonwealth.
(j) AIDS-related information on State employees, dependents and clients should be handled with strict confidentiality by agencies. Records should not be filed in the Official Personnel Folder. Supervisory and management employees shall assure confidentiality when handling AIDS-related employee information.

7.433. Agency AIDS policies.
State agencies that develop individualized AIDS work place policies should insure that their issuances are consistent with

this Commonwealth policy and with policies found in other State agencies. Agency policies shall be approved, in writing, by the Department of Health and the Office of Administration before issuance.

CHAPTER 27. COMMUNICABLE AND NONCOMMUNICABLE DISEASES

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Subchapter A. GENERAL PROVISIONS

Sec.
27.1. Definitions.
27.2. Reportable diseases.
27.3. Unusual or ill-defined diseases, illnesses or outbreaks.
27.4. Noncommunicable diseases and conditions.
27.5. Cancer Registry.

27.1. Definitions.

The following words and terms, when used in this chapter, have the following meanings, unless the context clearly indicates otherwise:

Act - Disease Prevention and Control Law of 1955 (35 P.S. 521.1-521.21).

Board-The Advisory Health Board of the Department.

Carrier-A person who, without any apparent symptoms of communicable disease, harbors a specific infectious agent and may serve as a source of infection.

Communicable disease-An illness due to an infectious agent or its toxic products which is transmitted, directly or indirectly, to a susceptible host from an infected person, animal or arthropod, or through the agency of an intermediate host, or a vector or through the inanimate environment.

Communicable period-The time during which the etiologic agent may be transferred directly or indirectly from an infected person to another person, or from an infected animal to a person.

Contact-A person or animal known to have been in association with an infected person or animal as to have had an opportunity of acquiring the infection.

County morbidity reporting area-A county so designated by the Board wherein initial reports for communicable and noncommunicable diseases are to be reported to the State health center of the Department.
Department-The Department of Health of the Commonwealth.
Isolation-The separation for the period of communicability of infected persons or animals from other persons or animals, in places and under conditions that prevents the direct or indirect transmission of the infectious agent from infected persons or animals to other persons or animals who are susceptible or who may spread the disease to others.
Local board-The board of health or the department of public health of a municipality of the first class, a county department of health or a joint county or joint municipal department of health.
Local health authority-The appropriate local health officer, local board or district director of the area.
Local health officer-The head of a local board.
Municipality-A city, borough, incorporated town or township.
Placarding-The posting on a home or other building of a sign or notice warning of the presence of communicable disease within and the danger of infection therefrom.
Quarantine-The limitation of freedom of movement of persons or animals who have been exposed to a communicable disease, for a period of time equal to the longest usual incubation period of the disease, in such manner as to prevent effective contact with those not exposed. A quarantine may be complete or one of the following types:
(i) Segregation-The separation for special control or observation of one or more persons or animals from other persons or animals to facilitate the control of a communicable disease.
(ii) Modified quarantine-A selected, partial limitation of freedom of movement determined on the basis of differences in susceptibility or danger of disease transmission which is designed to meet particular situations. Modified quarantine includes, but is not limited to, the exclusion of children from school and the prohibition, or the restriction, of those exposed to a communicable disease from engaging in particular occupations.
(iii) Surveillance-The close supervision of persons and animals exposed to a communicable disease without restricting their movement.
Regulation-A rule or regulation issued by the Board or an ordinance, rule or regulation enacted or issued by a local board.
Reportable disease-A communicable disease declared reportable by regulation; an unusual or group expression of illness which, in the opinion of the Department, may be a public health emergency;

noncommunicable diseases and conditions for which the Department may authorize reporting to provide data and information which, in the opinion of the Board, are needed in order to effectively carry out those programs of the Department designed to protect and promote the health of the people of this Commonwealth, or to determine the need for the establishment of the programs.
Secretary-The Secretary of the Department of Health.
State health center-The official headquarters of the Department in each county other than those organized as county departments of health.

27.2. Reportable diseases.
The Board declares the following communicable diseases, unusual outbreaks of illness, noncommunicable diseases and conditions to be reportable:
AIDS (Acquired Immune Deficiency Syndrome).
Amebiasis.
Animal bite.
Anthrax.
Botulism.
Brucellosis.
Campylobacteriosis.
Cancer.
Chlamydia trachomatis infections.
Cholera.
Diphtheria.
Encephalitis.
Food poisoning.
Giardiasis.
Gonococcal infections.
Guillain-Barre syndrome.
Haemophilus influenzae type b disease.
Hepatitis non-A non-B.
Hepatitis, viral, including Type A and Type B.
Histoplasmosis.
Kawasaki disease.
Legionnaires' disease.
Leptospirosis.
Lyme disease.
Lymphogranuloma venereum.
Malaria.
Measles.
Meningitis-all types.
Meningococcal disease.
Mumps.
Pertussis (whooping cough).
Plague.

Poliomyelitis.
Psittacosis (Ornithosis).
Rabies.
Reye's syndrome.
Rickettsial diseases including Rocky Mountain Spotted Fever.
Rubella (German Measles) and congenital rubella syndrome.
Salmonellosis.
Shigellosis.
Syphilis-all stages.
Tetanus.
Toxic shock syndrome.
Toxoplasmosis.
Trichinosis.
Tuberculosis-all forms.
Tularemia.
Typhoid.
Yellow Fever.

27.24. Reports by heads of institutions.
(a) Superintendents of hospitals or other persons in charge of an institution for the treatment of disease or of an institution maintaining dormitories and living rooms or of an orphanage shall notify the local health authorities having jurisdiction over the area in which the institution is located and the district director or county health officer upon the occurrence in or admission to the institution of a patient with a reportable disease and shall thereafter follow the advice and instructions of the health authorities for controlling the disease, but the notification may not relieve physicians of their duty to report in the manner set forth in 27.21 (relating to physicians who treat patients with reportable diseases including tuberculosis), cases which they may treat or examine in any such institution.
(b) Persons in charge of hospitals shall report cases of AIDS under 27.32 (relating to reporting AIDS).

27.25. Reports by other licensed health practitioners.
A chiropractor, dentist, nurse, optometrist, podiatrist or other licensed health practitioner having knowledge or suspicion of a reportable disease or condition, except cancer and AIDS, shall report promptly to the local board.

27.26. Reporting by householders and others.
A householder; proprietor of a hotel, rooming, lodging or boarding house; or other person having knowledge or suspicion of a reportable disease or condition, except cancer and AIDS, shall report this knowledge or suspicion promptly to the local board.

27.27. Revision of diagnosis by attending physician.
No diagnosis of a disease for which isolation or quarantine is required may be revised without the concurrence of the county health officer or the designated representative of the Department or the medical member of the local board.

27.28. Reporting unusual or ill-defined diseases or illnesses.
A person having knowledge of the occurrence of an unusual disease or group expression of illness which may be of public concern, whether or not it is known to be of a communicable nature, shall report it promptly to the local health officer; reports shall be made to the representative of the Department district director.

27.32. Reporting AIDS.
(a) Physicians and hospitals shall report cases of AIDS promptly to the Department of Health, Division of Acute Infectious Disease Epidemiology, Post Office Box 90, Harrisburg, Pennsylvania 17108, or to the local health department in the counties of Allegheny, Bucks, Chester, Erie and Philadelphia and in the cities of Allentown, Bethlehem and York when the individual who is the subject of the report is a resident of the county or city.
(b) Local health authorities receiving reports of AIDS cases shall forward completed case report forms to the Department of Health in a timely manner. Completed forms shall provide identifying information, including but not limited to, the name of the case, the individual's address and telephone number, the name of the individual's medical provider and the reporting source.

REPORTS BY LOCAL HEALTH OFFICERS
27.41. Individual case reports.
A health officer of a municipality shall report weekly to the appropriate county health authorities on the prescribed form each individual case of reportable disease or condition which has been reported to him during the week.

Subchapter E. PROCEDURE FOR TREATING EACH REPORTABLE DISEASE
Sec.
27.101. General.
27. 101a. Acquired Immune Deficiency Syndrome (AIDS).
27.102. Amebiasis (amebic dysentery).
27.103. Animal bites.
27.104. Anthrax.
27.105. Botulism.
27.106. Brucellosis.
27. 106a. Campylobacteriosis.
27.107. Cholera.

27.108. Diphtheria.
27.109. Encephalitis.
27.110. Food poisoning.
27.111. Giardiasis.
27.112. Gonococcal infections.
27.113a. Haemophilus influzenae Type b Disease.
27.113. Guillain-Barre Syndrome.

27.101. General.
This subchapter contains the names of reportable diseases in alphabetical order and prescribes, in each case, the general requirements for the control of the infected individual, his contacts and his environment.
Detailed requirements for reporting diseases are prescribed in Subchapter B (relating to reporting of diseases) and requirements for isolation and quarantine are prescribed in Subchapter C (relating to quarantine and isolation).

27.101a. Acquired Immune Deficiency Syndrome (AIDS).
(a) Reporting. Reports of AIDS cases shall be made to the Division of Acute Infectious Disease Epidemiology, Department of Health, or to the local health department, as specified in 27.32 (relating to reporting AIDS).
(b) Isolation, Observe blood/body fluid precautions. Observe precautions appropriate for other specific infections that occur in AIDS patients.
(c) Concurrent disinfection. Equipment contaminated with blood or semen shall be disinfected.
(d) Terminal disinfection. Thorough cleaning of the patient's environment is required upon the patient's discharge from a hospital room.
(e) Quarantine. No quarantine is required.
(f) Restrictions on infectious individuals. Restrictions on body fluid and organ donations shall conform to the following:
(1) AIDS cases, human immunodeficiency virus (HIV) infected persons and HIV antibody positive persons may not donate blood, plasma, semen, organs or other body tissues.
(2) Blood banks, sperm banks and hospitals may not accept for human use blood, plasma, semen, organs or other body tissues without obtaining prior evidence that the donor is HIV antibody negative. Transplants may be performed prior to receiving HIV test results if delay, due to performance of the test, would threaten the recipient's survival.

CHAPTER 90c. INDIVIDUAL APPLICATIONS-STATEMENT OF POLICY
90c.5. Underwriting questions.
(a) Information.

(1)Information asked of the applicant to underwrite the coverage is in the form of a single direct question, not a compound question or declaratory statement, and permits a direct response of known fact. This complies with 89.12(d) (relating to application forms).
(2)Additional information obtained by a telephone interview conducted after the application has been submitted to the company is not used to contest coverage, unless the additional information is agreed to in writing by the applicant.
(b) "Good health" question.
(1)An adult application does or does not contain a "good health" question if the application contains extensive health underwriting questions.
(2)An adult application does not contain a "good health" question if the application does not contain extensive health underwriting questions. Extensive health underwriting questions means questions concerning at least the common dread diseases and a broad range of common nonlife threatening health conditions.
(3)A juvenile application does or does not contain a "good health" question.
(c) Serious health condition.
(1)An adult application does or does not contain either of the following questions, or a similar question, if the application contains extensive health underwriting questions:
(i) "Had or been treated for any serious health condition?"
(ii) "Do you have any other impairment?"
(2)A juvenile application does or does not contain either of these questions, or a similar question, without extensive health underwriting questions.
(d) Alcohol and drug use.
(1)An application contains alcohol and drug use or dependency questions if the application clearly defines words such as "excessive," "dependency," "habitual," "abuse," "regular," and the like. An application does not contain these questions if the application does not clearly define "excessive," "dependency," "habitual," "abuse," "regular," and the like. In relation to alcohol, these words are defined in terms of number of drinks consumed per day or some similar measure. In relation to drugs, they are defined in terms of being treated by a doctor for drug use or dependency.
(2)Underwriting questions concerning treatment for alcohol or drug use or dependency are worded to permit responses of known fact.
(3) The following alcohol or drug questions do or do not appear:
(i) Have you been medically treated for or been medically advised to have treatment for alcoholism or drug use or

dependency?
(ii) Have you been treated for alcohol or drug use or dependency?
(iii) Have you joined a treatment organization because of alcohol or drug use or dependency?
(iv) Have you ever sought medical treatment for alcohol or drug use or dependency?
(v) Have you ever been hospitalized for drug or alcohol use or dependency?
(e) Subsequent application. If an application is taken subsequent to the taking of an original application, it does not contain questions that require the applicant to agree that his health on the date of the application is the same as it was when the original application was taken, unless the applicant has a copy of the original application. In addition, a subsequent application that refers to the original application is not used more than 180 days after the original application.
(f) AIDS questions. The following AIDS questions do or do not appear:
(1) Have you ever been treated for or ever had Acquired Immune Deficiency Syndrome (AIDS) or AIDS Related Complex (ARC)?
(2) Have you ever had a condition which you were medically advised is related to AIDS?
(3) Have you ever tested positively for HIV, AIDS or ARC?
NOTE: The Department considers valid testing to be the HTLV-III test. A company uses a positive response to require additional testing to confirm AIDS. The additional testing includes the HTLV-III test twice and the Western Blot Test on the same sample of blood. The company does not deny coverage or rate the coverage on incomplete testing.
(4) Have you ever had an immune deficiency disorder or disease of the lymphatic system or immune mechanism? This appears only if the question in paragraph (1) or (2) or a similar question appears on the application.
(g) Additional AIDS questions. The following AIDS questions do not appear:
(1) Have you received counseling for, or advice concerning, AIDS?
NOTE: Questioning a proposed insured's history of counseling concerning AIDS is an invasion of the applicant's privacy. Counseling by itself would not reveal anything pertinent to the underwriting process.
(2) Are you homosexual?
NOTE: Questioning a proposed insured's life style is an invasion of the proposed insured's privacy.
(3) Have you ever had a known indication or symptom of AIDS or ARC or other health condition?

NOTE: Questions about whether a proposed insured has had a known indication or symptom do not appear on an application. Unless a condition has been previously diagnosed or treated, this question places the applicant in the position of making a self-diagnosis. Also, it is difficult to define what constitutes a "known indication or symptom of."

(4) Have you ever had an AIDS related condition?

NOTE: "AIDS"/"AIDS Related Complex" is definitive. Conversely, "related conditions" is vague and not in compliance with 89.12(d).

(5) Have you ever had an AIDS Related Complex?

NOTE: "AIDS"/"AIDS Related Complex" is definitive. Conversely, "any AIDS related complex" erroneously suggests that there is more than one AIDS Related Complex.

(6) Have you ever had an AIDS related blood test?

NOTE: "AIDS related blood test" is vague and not in compliance with 89.12.

(h) Specific AIDS questions. The following questions do or do not appear with or without specific AIDS questions:

(1) Have you ever had, experienced, been tested for, treated for or told you had any of the following: Kaposi's Sarcoma, infections from Pneumocystis Carinii, Cytomegalovirus (CMV), enlargement of lymph nodes or glands, chronic diarrhea, unusual or persistent skin lesions, unexplained infections or chronic fatigue?

(2) Have you ever had major surgery that necessitated a blood transfusion?

(i) Blood transfusion. The following question does not appear: Have you ever had major surgery that necessitated, or may have necessitated, a blood transfusion?

(j) Medical consultation. An application does or does not contain a general question about a medical consultation or a visit to a physician, for example, "Have you within the past 10 years had a consultation?" or "When did you last see a physician?" If it does, the company certifies in writing that information obtained on the application about a medical consultation or informational visit concerning AIDS or ARC, as opposed to the diagnosis or treatment of AIDS or ARC, will never be used to underwrite coverage on a proposed insured.

(k) Church affiliation. An application does not contain a question (about the applicant's church affiliation. The agent's report does or does not contain a question concerning the applicant's church affiliation. If it does, the company certifies that the information is not used for underwriting purposes.

(1) Smoker or nonsmoker. Underwriting questions for the purpose of assigning a smoker or nonsmoker rating in determining the cash values of a fixed premium policy or rider and the cost of insurance rates of a flexible premium universal life policy or

rider are limited to questions about the proposed insured's tobacco use habits. With respect to the cost of insurance rates, this does not prevent the company from classifying a proposed insured, not an existing insured, who does not smoke a substandard nonsmoker based on medical history.

(m) Medical exam report. When using another company's medical exam report the following apply:

(1) The report is provided to the new company only by the applicant or with specific authorization in writing from the applicant.

(2) The new application that incorporates the other company's medical exam report provides for the applicant to state that the medical condition as stated in the medical exam report is unchanged only if the applicant has a copy of the report.

(3) The medical exam is no older than 180 days.

90c.25. AIDS.

Insurer practices that comply with the following are acceptable:

(1) For underwriting purposes, AIDS is considered to be the same as other medical conditions, such as cancer or heart disease.

(2) Information obtained through the underwriting process is confidential.

(3) Proposed insureds who are determined to have AIDS or ARC are insured at standard premiums, at higher than standard premiums, or rejected as insureds based on underwriting and any complete test results.

(4) An individual life insurance policy or annuity contract does not include a provision applicable to all life insureds or annuitants that excludes claims from any specific condition, such as AIDS.

CHAPTER 211. PROGRAM STANDARDS FOR LONG TERM CARE NURSING FACILITIES

211.1. Infection control.

(a) The facility shall establish an active Infection Control Committee composed of members of the medical and nursing staffs, administration, and dietetic, pharmacy, housekeeping, maintenance and other services charged with responsibility for overall infection control.

(b) The Infection Control Committee shall establish written policies and procedures for investigating, controlling and preventing infections in the facility, and for identifying patients with reportable diseases.

(c) The written policies and procedures in aseptic and isolation techniques shall be followed by personnel. If the facility does not have the capability of caring for a patient with an

infectious disease, the written policies shall include provisions for handling isolation cases until arrangements can be made to have the patient transferred to a facility capable of caring for the patient and the needs related to the specific organism.

(d) The Infection Control Committee shall monitor staff performance to ensure that policies and procedures are executed.

(e) Procedures shall be reviewed and revised for effectiveness and improvement at least annually or more frequently as necessary.

(f) Minutes shall be maintained for Committee meetings.

(g) A patient who develops a communicable disease after admission shall be medically isolated from other patients if ordered by the physician. If the patient cannot or should not be managed in the facility, arrangements shall be made by the attending physician for the transfer of the patient to an appropriate facility at the earliest practical time.

(h) When a patient develops a reportable disease, the administrator shall report the information to the appropriate health agencies and Long Term Care Field Office. Reportable diseases and conditions are:

Acquired Immune Deficiency Syndrome
Amebiasis
Animal bites
Anthrax
Botulism
Brucellosis
Campylobacteriosis
Cancer
Cholera
Diphtheria
Encephalitis
Food Poisoning
Giardiasis
Gonococcal Infections
Guillain-Barre Syndrome
Haemophilus influenzae type b disease
Hepatitis, Viral, including Type A and Type B
Hepatitis, non-A and non-B
Histoplasmosis
Kawasaki disease
Legionnaires' disease
Leptospirosis
Lyme disease
Lymphogranuloma venereum
Malaria
Measles
Meningitis-all types

Meningococcal Disease
Mumps
Pertussis (whooping cough)
Plague
Poliomyelitis
Psittacosis (ornithosis)
Rabies
Reye's syndrome
Rickettsial diseases, including Rocky Mounted Spotted Fever
Rubella (German measles) and congenital rubella syndrome
Salmonellosis
Shigellosis
Syphilis, all stages
Tetanus
Toxic Shock Syndrome
Toxoplasmosis
Trichinosis
Tuberculosis, all forms
Tularemia
Typhoid
Yellow Fever

(i) The following conditions shall be reported when diagnosis is confirmed by laboratory findings:

Amebiasis
Anthrax
Botulism
Brucellosis
Campylobacteriosis
Cholera
Diphtheria infections
Giardiasis
Gonococcal infections
Haemophilus influenzae type b disease
Hepatitis, viral, including types A and B
Hypothroidism in infant up to 24 months
Histoplasmosis
Lead poisoning
Legionnaires' disease
Leptospirosis
Lyme disease
Lymphogranuloma venereum
Malaria
Meningococcal isolations
Phenylketonuria
Plague
Psittacosis (ornithosis)
Rabies

Rickettsial infections including Rocky Mountain Spotted Fever
Salmonella isolations
Shigella isolations
Syphilis
Trichinosis
Tuberculosis
Tularemia
Typhoid isolations
Viral infections
Vaccine-preventable diseases
Arboviruses
Respiratory viruses

(j) If a communicable disease develops, adequate steps shall be taken to determine the source and degree of dissemination of the disease.

(k) Cases of scabies and lice shall be reported to the Long Term Care Field Office.

211.2. Medical services.

(a) The facility shall have or make provisions for a physician who shall be responsible for attending to the medical needs of the patients.

(b) A patient shall be under the current care of a physician. A skilled care patient shall be seen by the attending physician at least every 30 days and an intermediate care patient at least every 60 days, or more often as necessary.

(c) A patient's total program of care, including medications, care and treatments, shall be reviewed during a visit by the attending physician at least once every 30 days for a skilled care patient and every 60 days for an intermediate care patient. Revisions shall be made as necessary. The physician shall indicate on the patient's medical record that the review has been made. Entries made by the physician on the medical record shall be dated and signed with the original signature of the physician. A physician's orders shall be renewed at least once every 30 days for skilled care patients and every 60 days for intermediate care patients.

(d) The facility shall have written procedures available at each nurses station that provide for a physician to be available to furnish necessary medical care in case of emergency. The procedures shall be reviewed periodically to determine their effectiveness.

(e) The attending physician shall be responsible for the medical evaluation of the patient and shall prescribe a planned regimen of total patient care. This regimen shall incorporate all of the components of the patient's care and shall designate the patient's appropriate level of care.

(f) The facility shall have available, prior to or at the time of admission, patient information which includes current medical findings, diagnoses and orders from a physician for immediate care of the patient. Information shall also be available at the time of admission or within 48 hours thereafter, on the patient's rehabilitation potential and a summary of the course of prior treatment.

(g) The admission requirements shall include a report of physical examination, chest X-ray, complete blood count and urinalysis. These shall be done within 1 week prior to, or within 48 hours after admission. A chest X-ray taken within 60 days prior to admission will fulfill the admission requirement for a chest X-ray. When the patient is admitted to the facility directly from a hospital, the hospital report of these examinations and tests accompanying the patient shall be considered to meet this requirement, if the attending physician in the facility documents, in the patient record, that these reports are acceptable. When a patient is admitted to another level of care within a facility, or to another licensed nursing facility, the medical reports transferred with the patient shall be considered to meet this requirement, if the attending physician in the facility documents, in the patient's record, that these reports are acceptable.

(h) Annually thereafter, there shall be a physical examination, complete blood count and urinalysis completed for each patient. The results of the tests shall be available on the patient chart.

(i) A progress note shall be written or typed and signed and dated by the physician on the day the patient is seen.

(j) A physician's orders shall be dated and signed with the original signature of the physician.

(k) A facility shall have a medical director who is licensed as a physician in this Commonwealth and who is responsible for the overall coordination of the medical care in the facility to ensure the adequacy and -appropriateness of the medical services provided to the patients. The medical director may serve on a full- or part-time basis depending on the needs of the patients and the facility and may be designated for single or multiple facilities. There shall be a written agreement between the physician and the facility.

(l) The medical director's responsibilities shall include at least the following:

(1) Coordination of care of patients provided by attending physicians and ensurance of compliance with the facility's written bylaws and rules which delineate responsibilities.

(2) Review of incidents and accidents that occur on the premises and addressing the health and safety hazards of the facility. The administrator shall be given appropriate information from the

medical director to help insure a safe and sanitary environment for patients and personnel.
(3) Execution of patient care policies as they relate to the patient's total plan of care.
(4) Development of written policies which are approved by the governing body that delineate the responsibilities of attending physicians.
(m) The requirement for a medical director may be waived by the Department for an appropriate period of time depending on the following:
(1) The facility is located in an area where the supply of physicians is not sufficient to permit compliance with this requirement without seriously reducing the availability of physician services within the area.
(2) The facility has made continuous efforts in good faith to recruit a medical director but has not been able to hire a physician due to the unavailability of physicians.

211.3. Oral and telephone orders.
(a) A physician's oral and telephone orders shall be given to a licensed nurse, physician or other individual authorized by appropriate statutes and the State Boards in the Bureau of Professional and Occupational Affairs and shall immediately be recorded on the patient's medical record by the person receiving the order. The entry shall be signed and dated by the person receiving the order.
(b) A physician's oral and telephone orders for care and treatments, exclusive of medication orders-see 211.9(h) (relating to pharmaceutical services)-shall be dated and countersigned with the original signature of the physician within 7 days of receipt of the order. If the physician is not the attending physician, he shall be authorized and the facility so informed by the attending physician and shall be knowledgeable about the patient's condition.

211.4. Procedure in event of death.
(a) The patient's physician or the physician's designee shall be notified immediately of the apparent death of a patient. Documentation shall be on the patient's medical record of this notification or attempt to notify the physician.
(b) Written and dated documentation by the physician shall be on the patient's medical record that death has occurred.
(c) Death certificates shall be completed and signed by the physician under Article V of the Vital Statistics Law of 1953 (35 P.S. 450.501-450.5(6).
(d) Written postmortem procedures shall be available at each nursing station.

(e) Documentation shall be on the patient's medical record that the next of kin, guardian or responsible party has been notified of the patient's death. The name of the notified party shall be written on the patient's medical record.

211.5. Medical records.

(a) The facility shall maintain, in accordance with accepted professional standards and practices, an organized patient record system. These records shall be available to professional and other staff directly involved with the patient and to authorized representatives of the State and Federal government. Records shall be available to, but not be limited to, representatives of Department of Aging Ombudsman Program.

(b) The medical record service shall have sufficient staff, facilities and equipment to provide medical records that are documented completely and accurately, readily accessible and systematically organized to facilitate retrieving and compiling information.

(c) Information contained in the patient's record shall be privileged and confidential. Written consent of the patient, or of a designated responsible agent acting on the patient's behalf, is required for release of information. Written consent is not necessary for authorized representatives of the State and Federal government during the conduct of their official duties.

(d) The facility shall provide the patient or the patient designee, upon request, access to information contained in the patient's medical records unless medically contraindicated. If the patient or patient designee wants a copy of the medical record, the facility shall provide the copy and may charge a reasonable fee for reproducing copies.

(e) If requested, after the death of a patient, the facility shall make the patient's medical record available to the deceased patient's executor or administrator of the decedent's estate or to the person who is responsible for the disposition of the body. If a copy of the medical record is requested, the facility shall provide one copy and may charge a reasonable fee for reproducing copies.

(f) Records shall be adequately safeguarded against destruction, fire, loss or unauthorized use.

(g) The facility shall maintain adequate facilities and equipment, which are conveniently located, in order to provide efficient processing of medical records.

(h) Records shall be retained for a minimum of 7 years following a patient's discharge or death.

(i) Medical records of discharged patients shall be completed within 30 days of discharge. Clinical information pertaining to a patient's stay shall be centralized in the patient's medical record.

(j) When a facility closes, patient medical records may be transferred with the patient if the patient is transferred to another health care facility. Otherwise, the owners of the facility shall make provisions for the safekeeping and confidentiality of medical records and shall notify the Department of how the records may be obtained.

(k) At a minimum, the patient record shall include physicians' orders, observation and progress notes, nurses' notes, medical and nursing history and physical examination reports; identification information, admission data, documented evidence of assessment of patient's needs, establishment of an appropriate treatment plan and plans of care and services provided; hospital diagnoses authentication-discharge summary, report from attending physician, or transfer form-diagnostic and therapeutic orders, reports of treatments, clinical findings, medication records and discharge summary including final diagnosis and prognosis or cause of death. The information contained in the record shall be sufficient to justify the diagnosis and treatment, identify the patient and show accurately documented information.

(1) Symptoms and other indications of illness or injury, including the date, time and action taken shall be recorded.

(m) Each professional discipline shall enter the appropriate historical and progress notes in a timely fashion in accordance with the individual needs of a patient.

(n) Overall supervisory responsibility for the medical record service shall be assigned to a full-time employee of the facility. If the person is not a qualified medical records administrator, this person functions with consultation from a person so qualified. The facility shall also employ sufficient supportive personnel competent to carry out the functions of the medical record service.

(o) The following information shall be incorporated by members of the nursing staff into the nurses' notes section of the medical record:

(1) Drugs or treatment administered to patients shall be recorded daily on the proper record.

(2) Observations made concerning the condition of critically or acutely ill patients shall be recorded daily on the proper record on each tour of duty.

(3) Observations made concerning the condition of patients who are not critically or acutely ill shall be recorded in summary at least once each month for each tour of duty.

(4) Nurses' notes shall be written in chronological order and

shall be signed and dated by the person making the entry. Nurses' notes include, but are not limited to, observations made concerning the general condition of the patient, change in the physical or mental condition, an incident or accident and significant items of care.