902 KAR 20:200. Tuberculosis (TB) testing for residents in long-term care settings.

RELATES TO: KRS 215.520-215.600, 216B.010-216B.131, 216B.990

STATUTORY AUTHORITY: KRS 216B.042(1)

NECESSITY, FUNCTION, AND CONFORMITY: KRS 216B.042(1) requires the Cabinet for Health and Family Services to establish licensure standards and procedures to ensure safe, adequate, and efficient health facilities and health services. KRS 215.590 requires a health service or health facility licensed pursuant to KRS Chapter 216B or KRS Chapter 333 to report knowledge of a person who has active tuberculosis to the local health department. This administrative regulation establishes requirements for tuberculosis (TB) testing of residents in the following long-term care settings: nursing facilities, intermediate care facilities, nursing homes, Alzheimer's nursing homes, personal care homes, and intermediate care facilities for individuals with an intellectual disability (ICF/IID). These procedures are necessary to minimize the transmission of infectious tuberculosis among the staff and residents in long-term care settings.

Section 1. Definitions.

(1) "Air changes per hour" or "ACH" means the air change rate expressed as the number of air exchange units per hour.

(2) "Airborne Infection Isolation (AII) room" means a room, formerly called a negative pressure isolation room, which is designed to maintain AII and is a single-occupancy patient-care room used to isolate persons with suspected or confirmed infectious TB disease.

(3) "BAMT conversion" means a change in the BAMT test result, on serial testing, from negative to positive over a two (2) year period.

(4) "Blood Assay for Mycobacterium tuberculosis" or "BAMT" means a diagnostic blood test that:

(a) Assesses for the presence of infection with M. tuberculosis;

(b) Reports results as positive, negative, indeterminate, or borderline; and

(c) Includes interferon-gamma (IFN- ɣ) release assays (IGRA).

(5) "Boosting" or the "booster phenomenon" means if nonspecific or remote sensitivity to tuberculin purified protein derivative (PPD) in the skin test wanes or disappears over time, subsequent tuberculin skin tests (TSTs) may restore the sensitivity.

(6) "Directly observed preventive therapy" or "DOPT" means the DOT for treatment of LTBI.

(7) "Directly observed therapy" or "DOT" means an adherence-enhancing strategy:

(a) In which a health care worker or other trained person watches a patient swallow each dose of medication; and

(b) That is the standard care for all patients with TB disease and is a preferred option for patients treated for latent TB infection (LTBI).

(8) "Extrapulmonary tuberculosis" means TB disease in any part of the body other than the lungs (e.g., kidney, spine, or lymph nodes), and may include the presence of pulmonary TB or other infectious TB diseases.

(9) "Health care workers" or "HCWs" means all paid and unpaid persons working in health care settings who have the potential for exposure to infectious materials, including body substances, contaminated medical supplies and equipment, contaminated environmental surfaces, or contaminated air, and shall include:

(a) Physicians;

(b) Physician assistants;

(c) Nurses;

(d) Medical assistants;

(e) Nursing assistants or nurse aides;

(f) Therapists;
(g) Technicians;
(h) Emergency medical service personnel;
(i) Dental personnel;
(j) Pharmacists;
(k) Laboratory personnel;
(l) Autopsy personnel;
(m) Students and trainees;
(n) Contractual and community-based physicians and other healthcare professionals and staff not employed by the health care facility; and
(o) Persons (e.g., clerical, dietary, housekeeping, laundry, security, maintenance, billing, and volunteers) not directly involved in patient care but potentially exposed to infectious agents that may be transmitted to and from health care workers and patients or residents.

(10) "Induration" means a firm area in the skin that develops as a reaction to injected tuberculin antigen if a person has tuberculosis infection and that is measured in accordance with Section 2(2) of this administrative regulation.

(11) "Infectious tuberculosis" means pulmonary, laryngeal, endobroncheal, or tracheal TB disease or a draining TB skin lesion that has the potential to cause transmission of tuberculosis to other persons.

(12) "Latent TB infection" or "LTBI" means infection with M. tuberculosis without symptoms or signs of disease having been manifested.

(13) "Long-term care setting" means a nursing facility, intermediate care facility, nursing home, Alzheimer's nursing home, personal care home, or intermediate care facility for individuals with an intellectual disability.

(14) "Multidrug-resistant tuberculosis" or "MDR TB" means TB disease caused by M. tuberculosis organisms that are resistant to at least isoniazid (INH) and rifampin.

(15) "Nucleic Acid Amplification" or "NAA" means a laboratory method used to target and amplify a single deoxyribonucleic acid (DNA) or ribonucleic acid (RNA) sequence usually for detecting and identifying a microorganism.

(16) "Polymerase chain reaction" or "PCR" means a system for in vitro amplification of DNA or RNA that can be used for diagnosis of infections.

(17) "Staggered tuberculosis testing" means the testing of a resident in or before the same month as the anniversary date of the resident's admission, or testing in or before the birth month of the resident so that all residents do not have tuberculosis testing in the same month.

(18) "TST conversion" means a change in the result of a test for M. tuberculosis infection in which the condition is interpreted as having progressed from uninfected to infected in accordance with Section 2(4) of this administrative regulation.

(19) "Tuberculin skin test" or "TST" means a diagnostic aid for finding M. tuberculosis infection that:
(a) Is performed by using the intradermal (Mantoux) technique using five (5) tuberculin units of purified protein derivative (PPD); and
(b) Has its results read forty-eight (48) to seventy-two (72) hours after injection and recorded in millimeters of induration.

(20) "Tuberculosis (TB) disease" means a condition caused by infection with a member of the M. tuberculosis complex that meets the descriptions established in Section 2(3) of this administrative regulation.

(21) "Tuberculosis risk assessment" means an initial and ongoing evaluation of the risk for LTBI or active TB disease in a particular resident and is performed in accordance with the provisions established in Sections 3, 7, 8, and 11 of this administrative regulation.

(22) "Two-step TST" or "two-step testing" means a series of two (2) TSTs administered seven (7) to twenty-one (21) days apart and used for the baseline skin testing of persons who will receive serial TSTs, including health care workers and residents of long-term care settings to reduce the likelihood of mistaking a boosted reaction for a new infection.

Section 2. Tuberculosis Testing Requirements for TSTs.

(1) Two-step testing shall be used to distinguish new infections from boosted reactions in infection-control surveillance programs.

(2)

(a) A TST shall be performed by:

1. A physician;
2. An advanced practice registered nurse;
3. A physician assistant;
4. A registered nurse; or
5. A pharmacist.

(b) A licensed practical nurse under the supervision of a registered nurse may perform a TST.

(3) Induration Measurements.

(a) The diameter of the firm area shall be measured transversely (i.e., perpendicularly) to the long axis of the forearm to the nearest millimeter to gauge the degree of reaction, and the result shall be recorded in millimeters.

(b) The diameter of the firm area shall not be measured along the long axis of the forearm.

(c) A reaction of ten (10) millimeters or more of induration, if the TST result is interpreted as positive, shall be considered highly indicative of tuberculosis infection in a health care setting.

(d) A reaction of five (5) millimeters to nine (9) millimeters of induration may be significant in certain individuals with risk factors described in Section 3(3) of this administrative regulation for rapid progression to active tuberculosis disease if infected.

(4) Tuberculosis (TB) disease.

(a) A person shall be diagnosed as having tuberculosis (TB) disease if the infection has progressed to causing clinical (manifesting signs or symptoms) or subclinical (early stage of disease in which signs or symptoms are not present but other indications of disease activity are present, including radiographic abnormalities) illness.

1. Tuberculosis that is found in the lungs shall be called pulmonary TB and may be infectious.
2. Extrapulmonary disease (occurring at a body site outside the lungs) may be infectious in rare circumstances.

(b) If the only clinical finding is specific chest radiographic abnormalities, the condition is termed "inactive TB" and shall be differentiated from active TB disease, which is accompanied by symptoms or other indications of disease activity, including the ability to culture reproducing TB organisms from respiratory secretions or specific chest radiographic finding.

(5)

(a) A TST conversion shall have occurred if the size of the measured TST induration increases by ten (10) millimeters or more during a two (2) year period in a resident with a:

1. Documented baseline two-step TST result measured as zero (0); or
2. Previous follow-up screening TST result with induration measured as one (1) millimeter to nine (9) millimeters and interpreted as negative during serial testing.

(b) A TST conversion shall be presumptive evidence of new M. tuberculosis infection and poses an increased risk for progression to TB disease.

Section 3. TB Risk Assessment and Tuberculin Skin Tests or BAMTs for Residents.

(1) Risk Assessment.

(a) To perform a risk assessment, a questionnaire shall be used and the following factors shall be assessed:

1. The clinical symptoms of active TB disease;

2. Events and behaviors that increase the risk for exposure to M. tuberculosis and the risk of acquiring LTBI; and

3. Medical risk factors that increase the risk for a resident with LTBI to develop active TB disease.

(b) A TB Risk Assessment questionnaire may be obtained from the Kentucky Department for Public Health (published online at: http://chfs.ky.gov/dph/epi/tb.htm) or from a national medical or public health organization, including the American Academy of Pediatrics or the Centers for Disease Control and Prevention.

(c) TB Risk Assessment questions shall be on a facility-approved form or incorporated into the long-term care setting's medical forms or into forms or other features of the long-term care setting's electronic medical record systems.

(2) Exclusion of Residents from Tuberculin Skin Tests or BAMTs on Admission. A TST or BAMT shall not be required on admission if the resident, resident's guardian, resident's health care surrogate, or resident's responsible party provided medical documentation for one (1) of the following as part of a TB Risk Assessment:

(a) A prior TST of ten (10) or more millimeters of induration if the TST result was interpreted as positive;

(b) A prior TST of five (5) millimeters to nine (9) millimeters of induration if the resident has a medical reason as described in subsection (3) of this section for his or her TST result to be interpreted as positive;

(c) A positive BAMT;

(d) A TST conversion;

(e) A BAMT conversion;

(f) The resident is currently receiving or has completed treatment for LTBI with one (1) of the treatment regimens recommended by the Centers for Disease Control and Prevention;

(g) The resident has completed a course of multiple-drug therapy for active TB disease recommended by the Centers for Disease Control and Prevention; or

(h) The resident has had a TST or BAMT within three (3) months prior to admission and has previously been in a serial testing program at another medical facility, long-term care setting, or other health care setting.

(3) A medical reason for a resident's TST result of five (5) millimeters to nine (9) millimeters of induration to be interpreted as positive may include:

(a) HIV-infection;

(b) Immunosuppression from disease or medications;

(c) Fibrotic changes on a chest radiograph consistent with previous TB disease: or

(d) Recent contact with a person who has active TB disease.

(4) TB Risk Assessments and Tuberculin Skin Tests or BAMTs on Admission.

(a) A baseline TB Risk Assessment and a TST or BAMT, if not excluded pursuant to subsection (2) of this section, shall be initiated on each new resident before or during the first week of admission. The results shall be documented in the resident's medical record or electronic medical record within the first two (2) weeks of admission.

(b) A TB Risk Assessment required by paragraph (a) of this subsection and other sections of this administrative regulation shall be performed by:

1. A physician;
2. An advanced practice registered nurse;
3. A physician assistant;
4. A registered nurse; or
5. A pharmacist.

(c) A licensed practical nurse under the supervision of a registered nurse may perform the TB Risk Assessment.

(d) An initial or first-step TST result of ten (10) millimeters or more of induration may be interpreted as positive for a new resident.

(e) An initial or first-step TST result on admission of five (5) to nine (9) millimeters of induration may be interpreted as positive for a resident who has a medical reason as described in subsection (3) of this section for the TST result to be interpreted as positive.

(5)

(a) A two-step baseline TST shall be required on admission for each resident aged fourteen (14) years and older whose initial or first-step TST on admission is interpreted as negative.

(b) The second-step test shall be initiated seven (7) to twenty-one (21) days after the first test.

1. A TST result of five (5) millimeters to nine (9) millimeters of induration may be interpreted as positive on the second step TST for a resident who has a medical reason as described in subsection (3) of this section for the TST result to be interpreted as positive.

2. If a resident aged fourteen (14) years and older does not have a medical reason as identified in subsection (3) of this section and the resident's initial or first-step TST performed in accordance with subsection (4)(a) of this section shows less than ten (10) millimeters of induration and a second step TST shows more than ten (10) millimeters of induration, the TST shall be interpreted as positive.

3. The initial TST shall count as the second-step TST if the resident aged fourteen (14) years and older provided medical documentation that he or she has had a one-step TST interpreted as negative within one (1) year prior to initial testing upon admission to the long-term care setting.

(6) A BAMT may be used in place of, but not in addition to, a TST and:

(a) If a BAMT is performed before or during the first week of admission and the result is positive or negative, only one (1) BAMT test result shall be required; and

(b) A second BAMT shall be performed if the BAMT result is borderline, indeterminate, or invalid.

Section 4. Admission of Patients under Treatment for Pulmonary Tuberculosis Disease or Other Infectious Tuberculosis Diseases.

(1) A long-term care setting as described in Section 1(13) of this administrative regulation shall not admit a person under medical treatment for suspected or confirmed pulmonary tuberculosis disease or other suspected or confirmed infectious tuberculosis diseases caused by either non-MDR TB or MDR-TB unless the person is declared noninfectious by a licensed physician, advanced practice registered nurse, or physician assistant in conjunction with the local and state health departments.

(2)

(a) A long-term care setting as described in Section 1(13) of this administrative regulation shall not admit a person under medical treatment for suspected or confirmed extrapulmonary tuberculosis disease caused by non-MDR TB or MDR TB, unless the person is declared noninfectious by a licensed physician, advanced practice registered nurse, or physician assistant in conjunction with the local and state health departments.

(b) Documentation of noninfectious status shall include clinical, radiographic, and laboratory evidence that concurrent pulmonary TB disease or other infectious TB disease has been excluded.

Section 5. Medical Record or Electronic Medical Record Documentation for Residents.

(1) The TB Risk Assessment shall be documented in the resident's medical record or electronic medical record by recording the date of the assessment and the results.

(2) The TST result of each resident shall be documented in the resident's medical record or electronic medical record by recording the date of measurement, millimeters of induration, and interpretation of the results of all TSTs.

(3) The medical record shall be labeled inside or the electronic medical record shall be labeled with the notation "TST Positive" for each resident with a reaction of:

(a) Ten (10) millimeters or more of induration if the TST result was interpreted as positive; or

(b) Five (5) millimeters to nine (9) millimeters of induration if the resident has a medical reason as described in Section 3(3) of this administrative regulation for the TST result to be interpreted as positive.

(4)

(a) If performed, the BAMT result of each resident shall be documented in the resident's medical record or electronic medical record by recording the date and result as positive, negative, borderline, or indeterminate.

(b) If a resident has a positive BAMT, his or her medical record shall be labeled inside or electronic medical record shall be labeled with the notation "BAMT Positive."

Section 6. Medical Evaluations, Chest X-rays, and Monitoring of Residents with a Positive TST, a Positive BAMT, a TST Conversion, or a BAMT Conversion.

(1) At the time of admission or annual testing, a resident shall have a medical evaluation, including an HIV test unless the resident, resident's guardian, resident's health care surrogate, or resident's responsible party opts out of HIV testing, if the resident is found to have a:

(a) TST result of ten (10) millimeters or more induration if the TST result is interpreted as positive;

(b) TST result of five (5) millimeters to nine (9) millimeters of induration if the resident has a medical reason as described in Section 3(3) of this administrative regulation for the TST result to be interpreted as positive;

(c) Positive BAMT;

(d) TST conversion; or

(e) BAMT conversion.

(2) A chest x-ray shall be performed as part of the medical evaluation required by subsection (1) of this section unless a chest x-ray performed within the previous two (2) months showed no evidence of tuberculosis disease.

(3)

(a) A resident with no clinical evidence of active TB disease upon evaluation by a licensed physician, advanced practice registered nurse, or physician assistant, and a negative chest x-ray shall be offered treatment for LTBI unless there is a medical contraindication.

(b) A resident who refuses treatment for LTBI, or a resident whose guardian, health care surrogate, or responsible party refuses on behalf of the resident treatment for LTBI, or a resident who has a medical contraindication shall be monitored according to the requirements in Section 7 of this administrative regulation.

(4) A resident with symptoms or an abnormal chest x-ray consistent with TB disease shall be:

(a) Isolated in an AII room or transferred within eight (8) hours of facility staff being aware of a suspected TB diagnosis to a facility with an AII room; and

(b) Evaluated for active tuberculosis disease as established in this paragraph.

1. Three (3) sputum specimens collected eight (8) to twenty-four (24) hours apart with at least one (1) being an early morning specimen shall be submitted to a hospital laboratory or a state or national reference laboratory for tuberculosis culture, AFB smear, and NAA or PCR tests.

2. Multi-drug antituberculosis treatment shall be administered by DOT for suspected or active tuberculosis disease.

(5) Individuals under treatment for suspected or confirmed pulmonary tuberculosis disease or other suspected or confirmed infectious tuberculosis diseases may be readmitted to the long-term care setting in accordance with the requirements of Section 4 of this administrative regulation.

Section 7. Monitoring of Residents with a Positive TST, a Positive BAMT, a TST Conversion, or a BAMT Conversion.

(1) A resident shall be monitored for development of pulmonary symptoms, including cough, sputum production, and chest pain, if the resident has:

(a) A TST result with ten (10) or more millimeters of induration;

(b) A TST result of five (5) millimeters to nine (9) millimeters of induration if the resident has a medical reason as described in Section 3(3) of this administrative regulation for his or her TST result to be interpreted as positive;

(c) A positive BAMT;

(d) A TST conversion; or

(e) A BAMT conversion.

(2) If pulmonary symptoms, including cough, sputum production, and chest pain develop and persist for three (3) weeks or longer:

(a) The resident shall have a medical evaluation; and

(b) A chest x-ray shall be taken.

(3) A resident with symptoms or an abnormal chest x-ray consistent with TB disease shall be:

(a) Isolated in an AII room; or

(b) Transferred within eight (8) hours of facility staff being aware of a suspected TB diagnosis to a facility with an AII room.

(4) Three (3) sputum specimens collected eight (8) to twenty-four (24) hours apart with at least one (1) being an early morning specimen shall be submitted to a hospital laboratory or national reference laboratory for tuberculosis culture, AFB smear, and NAA or PCR tests.

(5) Multi-drug antituberculosis treatment shall be administered by DOT for suspected or active tuberculosis disease.

(6) Individuals under treatment for suspected or confirmed pulmonary tuberculosis disease or other suspected or confirmed infectious tuberculosis diseases may be readmitted to the long-term setting in accordance with the requirements of Section 3 of this administrative regulation.

(7)

(a) A resident with a positive TST or a positive BAMT on admission who stays eleven (11) months or longer in the long-term care setting shall have an annual TB Risk Assessment in or before the same month as the anniversary date of his or her last TB Risk Assessment.

(b) The resident shall not be required to submit to an annual TST or BAMT.

(8) A resident with a TST conversion or a BAMT conversion shall:

(a) Be educated about and advised of the clinical symptoms of active TB disease;

(b) Have an interval medical history for clinical symptoms of active TB disease every six (6) months during the first two (2) years following TST conversion or BAMT conversion followed thereafter by an annual TB Risk Assessment in or before the same month as the anniversary date of his or her last TB Risk Assessment; and

(c) Not be required to submit to an annual TST or BAMT.

Section 8. Monitoring of Residents with a Negative TST or a Negative BAMT who are Residents for Eleven (11) Months or Longer.

(1) A long-term care setting shall use staggered tuberculosis testing to assure that all residents are not tested in the same month. Staggered testing shall be performed monthly, quarterly, or semiannually.

(2) An annual TB Risk Assessment and a TST or BAMT shall be required in or before the same month as the anniversary date of the resident's last TB Risk Assessment and TST or BAMT.

(3)

(a) If pulmonary symptoms, including cough, sputum production, and chest pain, develop and persist for three (3) weeks or longer:

1. The resident shall have a medical evaluation;
2. The TST or BAMT shall be repeated; and
3. A chest x-ray shall be taken.

(b) A resident with signs or symptoms or an abnormal chest x-ray, consistent with TB disease, shall be:

1.

a. Isolated in an AII room; or

b. Transferred within eight (8) hours of facility staff being aware of a suspected TB diagnosis to a facility with an AII room; and

2. Evaluated for active tuberculosis disease as provided in this subparagraph.

a. Three (3) sputum specimens, collected eight (8) to twenty-four (24) hours apart with at least one (1) being an early morning specimen, shall be submitted to a hospital laboratory or a state or national reference laboratory for tuberculosis culture, AFB smear, and NAA tests or PCR tests.

b. Multi-drug antituberculosis treatment shall be administered by DOT for suspected or active tuberculosis disease.

(4) Individuals under treatment for suspected or confirmed pulmonary tuberculosis disease or other suspected or confirmed infectious tuberculosis diseases may be readmitted to the long-term care setting in accordance with the requirements of Section 4 of this administrative regulation.

(5) Individuals evaluated for suspected infectious TB disease of the lungs, airways, or larynx in which active TB disease is considered unlikely after medical evaluation and TB laboratory testing may be readmitted to the long-term care setting if the individual is declared noninfectious for TB by a licensed physician, advanced practice registered nurse, or physician assistant in conjunction with the local and state health departments.

Section 9. Responsibility for Screening and Monitoring Requirements: Residents.

(1) A long-term care setting's administrator or administrator's designee shall be responsible for ensuring that all TB Risk Assessments, TSTs, BAMTs, chest x-rays, and sputum specimen submissions for residents comply with Section 2 through Section 8 of this administrative regulation.

(2) If a long-term care setting does not employ licensed professional staff with the technical training to carry out the screening and monitoring requirements for residents, the administrator shall arrange for training or professional assistance from the local health department or from a licensed medical provider.

(3) TSTs with the date of measurement and millimeters of induration, interpretation of the results, date performed, and reported results of all BAMTs, chest x-rays, sputum specimen AFB smears, TB cultures, TB-related NAA tests, and TB-related PCR tests for a resident shall be:

(a) Recorded as a permanent part of the resident's medical record or electronic medical record; and

(b) Summarized on the resident's transfer form if an inter-facility transfer occurs.

Section 10. Reporting to Local Health Departments.

(1) A long-term care setting's administrator or the administrator's designee shall report a resident identified with one (1) of the following to the local health department having jurisdiction within one (1) business day upon becoming known:

(a) A TST conversion or BAMT conversion on serial testing or identified in a contact investigation;

(b) A chest x-ray which is suspicious for TB disease;

(c) A sputum smear positive for acid-fast bacilli;

(d) A rapid laboratory test positive for Mycobacterium tuberculosis DNA or RNA, such as Mycobacterium tuberculosis positive NAA tests or PCR tests;

(e) Sputum cultures positive for Mycobacterium tuberculosis; or

(f) The initiation of multi-drug antituberculosis treatment for a resident.

(2) A long-term care setting's administrator or the administrator's designee shall report a resident identified with one (1) of the following to the local health department having jurisdiction within five (5) business days upon becoming known:

(a) A TST of ten (10) millimeters or more induration at the time of admission if the TST result was interpreted as positive;

(b) A TST result of five (5) millimeters to nine (9) millimeters of induration at the time of admission for a resident who has a medical reason as described in Section 3(3) of this administrative regulation for his or her TST result to be interpreted as positive; or

(c) A positive BAMT at the time of admission.

Section 11. Treatment for LTBI in Residents.

(1) A resident with a TST conversion or a BAMT conversion with no clinical evidence of active TB disease upon evaluation by a licensed physician, advanced practice registered nurse, or physician assistant and a negative chest x-ray shall be considered to be recently infected with Mycobacterium tuberculosis.

(2) A recently infected person as described in subsection (1) of this section shall have:

(a) A medical evaluation;

(b) An HIV test unless the resident, resident's guardian, resident's health care surrogate, or resident's responsible party opts out of HIV testing; and

(c) A chest x-ray.

(3)

(a) A resident who meets the criteria in subsection (1) of this section and who has no signs or symptoms of tuberculosis disease by medical evaluation or on chest x-ray shall be offered treatment for LTBI, in collaboration with the local health department, unless medically contraindicated as determined by a licensed physician, advanced practice registered nurse, or physician assistant.

(b) Medications shall be:

1. Administered to residents upon the written order of a physician or other licensed medical provider acting within his or her statutory scope of practice; and

2. Given by DOPT.

(4) If a resident, resident's guardian, resident's health care surrogate, or resident's responsible party refuses treatment of the resident for LTBI after a TST conversion or a BAMT conversion or has a medical contraindication:

(a) The individual shall be educated about and advised of the clinical symptoms of active TB disease;

(b) The resident shall have a TB Risk Assessment which includes an interval medical history for clinical symptoms of active TB disease every six (6) months during the first two (2) years following TST conversion or BAMT conversion, followed thereafter by an annual TB Risk Assessment in or before the same month as the anniversary date of the resident's last TB Risk Assessment;

(c) The resident shall not be required to submit to an annual TST or BAMT; and

(d) Documentation that the resident, resident's guardian, resident's heath care surrogate, or resident's responsible party was educated and advised of the clinical symptoms of active TB shall be documented in the resident's medical record or electronic medical record.

(5) A resident who has a TST result of ten (10) millimeters or more induration, if the TST result is interpreted as positive, or has a positive BAMT at the time of admission shall be offered treatment for LTBI, unless medically contraindicated.

(6) A resident who has a TST result of five (5) millimeters to nine (9) millimeters of induration at the time of admission and who has a medical reason as described in Section 3(3) in this administrative regulation for his or her TST result to be interpreted as positive shall be offered treatment for LTBI, unless medically contraindicated.

(7) If a resident, resident's guardian, resident's health care surrogate, or resident's responsible party refuses treatment on behalf of the resident for LTBI detected upon admission:

(a) The individual shall be educated about and advised of the clinical symptoms of active TB disease;

(b) The resident shall have a TB Risk Assessment that includes an interval medical history for clinical symptoms of active TB disease every six (6) months during the first two (2) years following admission, followed thereafter by an annual TB Risk Assessment in or before the same month as the anniversary date of the resident's last TB Risk Assessment; and

(c) The resident shall not be required to submit to an annual TST or BAMT.

(8) Documentation that the resident, resident's guardian, resident's health care surrogate, or resident's responsible party was educated about and advised of the clinical symptoms of active TB shall be documented in the resident's medical record or electronic medical record.

(9)

(a) A resident who stays eleven (11) months or longer in the long-term care setting and who provided medical documentation for completion of treatment for LTBI with one (1) of the treatment regimens recommended by the Centers for Disease Control and Prevention shall not be required to submit to an annual TST or BAMT.

(b) The resident, resident's guardian, resident's health care surrogate, or resident's responsible party shall receive education on the clinical symptoms of active TB disease during a TB Risk Assessment annually in or before the same month as the anniversary date of the resident's last TB Risk Assessment and any other monitoring in accordance with Section 6 through Section 9 of this administrative regulation.

Section 12. Compliance Date. All health care settings or health facilities subject to the tuberculosis testing requirements of this administrative regulation shall demonstrate compliance no later than 180 days after the effective date of this administrative regulation.

Section 13. Supersede. If any requirement stated in another administrative regulation within 902 KAR Chapter 20 contradicts a requirement stated in this administrative regulation, the requirement stated in this administrative regulation shall supersede the requirement stated elsewhere within 902 KAR Chapter 20.

(11 Ky.R. 914; eff. 12-11-1984; Am. 12 Ky.R. 65; eff. 8-13-1985; 13 Ky.R. 1302; eff. 2-10-1987; 18 Ky.R. 1443; eff. 1-10-1992; 42 Ky.R. 1403; 2369; eff. 3-4-2016; Cert. eff. 12-14-2022.)