

1 **902 KAR 20:200. Tuberculosis (TB) testing for residents in long-term care**
2 **settings.**

3
4 RELATES TO: KRS 215.520-215.600, 216B.010-216B.131, 216B.990

5 STATUTORY AUTHORITY: KRS 216B.042(1)

6 NECESSITY, FUNCTION, AND CONFORMITY: KRS 216B.042(1) requires the
7 Cabinet for Health and Family Services to establish licensure standards and procedures
8 to ensure safe, adequate, and efficient health facilities and health services. KRS
9 215.590 requires a health service or health facility licensed pursuant to KRS Chapter
10 216B or KRS Chapter 333 to report knowledge of a person who has active tuberculosis
11 to the local health department. This administrative regulation establishes requirements
12 for tuberculosis (TB) testing of residents in the following long-term care settings: nursing
13 facilities, intermediate care facilities, nursing homes, Alzheimer's nursing homes,
14 personal care homes, and intermediate care facilities for individuals with an intellectual
15 disability (ICF/IID). These procedures are necessary to minimize the transmission of
16 infectious tuberculosis among the staff and residents in long-term care settings.

17
18 Section 1. Definitions. (1) "Air changes per hour" or "ACH" means the air change
19 rate expressed as the number of air exchange units per hour.

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

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

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

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

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

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

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

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

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

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

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

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

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

- 5 (a) Physicians;
- 6 (b) Physician assistants;
- 7 (c) Nurses;
- 8 (d) Medical assistants;
- 9 (e) Nursing assistants or nurse aides;
- 10 (f) Therapists;
- 11 (g) Technicians;
- 12 (h) Emergency medical service personnel;
- 13 (i) Dental personnel;
- 14 (j) Pharmacists;
- 15 (k) Laboratory personnel;
- 16 (l) Autopsy personnel;
- 17 (m) Students and trainees;

18 (n) Contractual and community-based physicians and other healthcare professionals
19 and staff not employed by the health care facility; and

20 (o) Persons (e.g., clerical, dietary, housekeeping, laundry, security, maintenance,
21 billing, and volunteers) not directly involved in patient care but potentially exposed to
22 infectious agents that may be transmitted to and from health care workers and patients
23 or residents.

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

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

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

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

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

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

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

42 (17) "Staggered tuberculosis testing" means the testing of a resident in or before the
43 same month as the anniversary date of the resident's admission, or testing in or before

1 the birth month of the resident so that all residents do not have tuberculosis testing in
2 the same month.

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

6 (19) "Tuberculin skin test" or "TST" means a diagnostic aid for finding M.
7 tuberculosis infection that:

8 (a) Is performed by using the intradermal (Mantoux) technique using five (5)
9 tuberculin units of purified protein derivative (PPD); and

10 (b) Has its results read forty-eight (48) to seventy-two (72) hours after injection and
11 recorded in millimeters of induration.

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

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

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

24
25 Section 2. Tuberculosis Testing Requirements for TSTs. (1) Two-step testing shall
26 be used to distinguish new infections from boosted reactions in infection-control
27 surveillance programs.

28 (2)(a) A TST shall be performed by:

- 29 1. A physician;
- 30 2. An advanced practice registered nurse;
- 31 3. A physician assistant;
- 32 4. A registered nurse; or
- 33 5. A pharmacist.

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

36 (3) Induration Measurements.

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

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

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

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

4 (4) Tuberculosis (TB) disease.

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

9 1. Tuberculosis that is found in the lungs shall be called pulmonary TB and may be
10 infectious.

11 2. Extrapulmonary disease (occurring at a body site outside the lungs) may be
12 infectious in rare circumstances.

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

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

21 1. Documented baseline two-step TST result measured as zero (0); or

22 2. Previous follow-up screening TST result with induration measured as one (1)
23 millimeter to nine (9) millimeters and interpreted as negative during serial testing.

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

26
27 Section 3. TB Risk Assessment and Tuberculin Skin Tests or BAMTs for Residents.
28 (1) Risk Assessment.

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

31 1. The clinical symptoms of active TB disease;

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

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

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

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

43 (2) Exclusion of Residents from Tuberculin Skin Tests or BAMTs on Admission. A
44 TST or BAMT shall not be required on admission if the resident, resident's guardian,

1 resident's health care surrogate, or resident's responsible party provided medical
2 documentation for one (1) of the following as part of a TB Risk Assessment:

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

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

8 (c) A positive BAMT;

9 (d) A TST conversion;

10 (e) A BAMT conversion;

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

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

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

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

21 (a) HIV-infection;

22 (b) Immunosuppression from disease or medications;

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

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

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

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

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

32 1. A physician;

33 2. An advanced practice registered nurse;

34 3. A physician assistant;

35 4. A registered nurse; or

36 5. A pharmacist.

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

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

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

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

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

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

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

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

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

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

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

24
25 Section 4. Admission of Patients under Treatment for Pulmonary Tuberculosis
26 Disease or Other Infectious Tuberculosis Diseases. (1) A long-term care setting as
27 described in Section 1(13) of this administrative regulation shall not admit a person
28 under medical treatment for suspected or confirmed pulmonary tuberculosis disease or
29 other suspected or confirmed infectious tuberculosis diseases caused by either non-
30 MDR TB or MDR-TB unless the person is declared noninfectious by a licensed
31 physician, advanced practice registered nurse, or physician assistant in conjunction with
32 the local and state health departments.

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

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

41
42 Section 5. Medical Record or Electronic Medical Record Documentation for
43 Residents. (1) The TB Risk Assessment shall be documented in the resident's medical

1 record or electronic medical record by recording the date of the assessment and the
2 results.

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

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

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

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

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

16 (b) If a resident has a positive BAMT, his or her medical record shall be labeled
17 inside or electronic medical record shall be labeled with the notation "BAMT Positive."
18

19 Section 6. Medical Evaluations, Chest X-rays, and Monitoring of Residents with a
20 Positive TST, a Positive BAMT, a TST Conversion, or a BAMT Conversion. (1) At the
21 time of admission or annual testing, a resident shall have a medical evaluation,
22 including an HIV test unless the resident, resident's guardian, resident's health care
23 surrogate, or resident's responsible party opts out of HIV testing, if the resident is found
24 to have a:

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

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

30 (c) Positive BAMT;

31 (d) TST conversion; or

32 (e) BAMT conversion.

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

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

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

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

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

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

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

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

12 (5) Individuals under treatment for suspected or confirmed pulmonary tuberculosis
13 disease or other suspected or confirmed infectious tuberculosis diseases may be
14 readmitted to the long-term care setting in accordance with the requirements of Section
15 4 of this administrative regulation.

16
17 Section 7. Monitoring of Residents with a Positive TST, a Positive BAMT, a TST
18 Conversion, or a BAMT Conversion. (1) A resident shall be monitored for development
19 of pulmonary symptoms, including cough, sputum production, and chest pain, if the
20 resident has:

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

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

25 (c) A positive BAMT;

26 (d) A TST conversion; or

27 (e) A BAMT conversion.

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

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

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

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

34 (a) Isolated in an All room; or

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

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

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

43 (6) Individuals under treatment for suspected or confirmed pulmonary tuberculosis
44 disease or other suspected or confirmed infectious tuberculosis diseases may be

1 readmitted to the long-term setting in accordance with the requirements of Section 3 of
2 this administrative regulation.

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

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

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

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

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

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

15
16 Section 8. Monitoring of Residents with a Negative TST or a Negative BAMT who
17 are Residents for Eleven (11) Months or Longer. (1) A long-term care setting shall use
18 staggered tuberculosis testing to assure that all residents are not tested in the same
19 month. Staggered testing shall be performed monthly, quarterly, or semiannually.

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

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

25 1. The resident shall have a medical evaluation;

26 2. The TST or BAMT shall be repeated; and

27 3. A chest x-ray shall be taken.

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

30 1.a. Isolated in an All room; or

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

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

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

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

40 (4) Individuals under treatment for suspected or confirmed pulmonary tuberculosis
41 disease or other suspected or confirmed infectious tuberculosis diseases may be
42 readmitted to the long-term care setting in accordance with the requirements of Section
43 4 of this administrative regulation.

1 (5) Individuals evaluated for suspected infectious TB disease of the lungs, airways,
2 or larynx in which active TB disease is considered unlikely after medical evaluation and
3 TB laboratory testing may be readmitted to the long-term care setting if the individual is
4 declared noninfectious for TB by a licensed physician, advanced practice registered
5 nurse, or physician assistant in conjunction with the local and state health departments.
6

7 Section 9. Responsibility for Screening and Monitoring Requirements: Residents. (1)
8 A long-term care setting's administrator or administrator's designee shall be responsible
9 for ensuring that all TB Risk Assessments, TSTs, BAMTs, chest x-rays, and sputum
10 specimen submissions for residents comply with Section 2 through Section 8 of this
11 administrative regulation.

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

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

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

22 (b) Summarized on the resident's transfer form if an inter-facility transfer occurs.
23

24 Section 10. Reporting to Local Health Departments. (1) A long-term care setting's
25 administrator or the administrator's designee shall report a resident identified with one
26 (1) of the following to the local health department having jurisdiction within one (1)
27 business day upon becoming known:

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

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

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

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

34 (e) Sputum cultures positive for Mycobacterium tuberculosis; or

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

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

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

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

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

1
2 Section 11. Treatment for LTBI in Residents. (1) A resident with a TST conversion
3 or a BAMT conversion with no clinical evidence of active TB disease upon evaluation by
4 a licensed physician, advanced practice registered nurse, or physician assistant and a
5 negative chest x-ray shall be considered to be recently infected with Mycobacterium
6 tuberculosis.

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

9 (a) A medical evaluation;

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

12 (c) A chest x-ray.

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

18 (b) Medications shall be:

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

21 2. Given by DOPT.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

25
26 Section 12. Compliance Date. All health care settings or health facilities subject to
27 the tuberculosis testing requirements of this administrative regulation shall demonstrate
28 compliance no later than 180 days after the effective date of this administrative
29 regulation.

30
31 Section 13. Supersede. If any requirement stated in another administrative
32 regulation within 902 KAR Chapter 20 contradicts a requirement stated in this
33 administrative regulation, the requirement stated in this administrative regulation shall
34 supersede the requirement stated elsewhere within 902 KAR Chapter 20. (11 Ky.R. 914;
35 eff. 12-11-1984; Am. 12 Ky.R. 65; eff. 8-13-1985; 13 Ky.R. 1302; eff. 2-10-1987; 18 Ky.R.
36 1443; eff. 1-10-1992; 42 Ky.R. 1403; 2369; eff. 3-4-2016.)