APA-1
6/93

TRANSMITTAL SHEET FOR NOTICE OF INTENDED ACTION

Control 420 Department or Agency Alabama Department of Public Health

Rule Number 420-5-4-.05
Rule Title Records and Reports

_____ New XXX Amend _____ Repeal _____ Adopt by Reference

Would the absence of the proposed rule significantly harm or endanger the public health, welfare or safety?	Yes
Is there a reasonable relationship between the state's police power and the protection of the public health, safety or welfare?	Yes
Is there another, less restrictive method of regulation available that could adequately protect the public?	No
Does the proposed rule have the effect of directly or indirectly increasing the costs of any goods or services involved and, if so, to what degree?	No
Is the increase in cost, if any, more harmful to the public than the harm that might result from the absence of the proposed rule?	NA
Are all facts of the rulemaking process designed solely for the purpose of and so they have as their primary effect, the protection of the public?	Yes
Does the proposed rule have an economic impact?	No

If the proposed rule has an economic impact, the proposed rule is required to be accompanied by a fiscal note prepared in accordance with subsection (f) of §41-22-23, Code of Alabama, 1975.

Certification of Authorized Official

I certify that the attached proposed rule has been in full compliance with the requirements of Chapter 22, Title 41, Code of Alabama, 1975, and that it conforms to all applicable filing requirements of the Administrative Procedure Division of the Legislative Reference Service.

Signature of Certifying Officer _____ Date 5/20/15

FORM APA2
11/96

STATE BOARD OF HEALTH
NOTICE OF INTENDED ACTION

AGENCY NAME: Alabama Department of Public Health

RULE NUMBER AND TITLE: 420-5-4-.05 Records and Reports

INTENDED ACTION: To Amend

SUBSTANCE OF PROPOSED ACTION: To eliminate redundant word usage; to update the communication method for incident reports using a secure online web portal rather than reporting by fax.

TIME, PLACE, AND MANNER OF PRESENTING VIEWS: A public hearing will be held at 9:00 a.m. on June 16, 2015, at the Alabama Department of Public Health, RSA Tower, Suite 1540, 201 Monroe St., Montgomery, AL 36104.

FINAL DATE FOR COMMENTS AND COMPLETION OF NOTICE: Written or oral comments will be received until the close of the record at 5:00 p.m. on July 3, 2015. All comments and requests for copies of the proposed amendments should be addressed to the contact person listed below.

CONTACT PERSON AT AGENCY: Ray Sherer, Division of Provider Services, Department of Public Health, P.O. Box 303017, Montgomery, Alabama 36130-3017.
Telephone number: (334) 206-5175.

P. Brian Hale, Agency Secretary

420-5-4-.05 Records And Reports.

(1) General.

(a) Responsibility for Records. The administrator shall prepare and file all records, or shall oversee the preparation and filing of records. This duty shall be assigned to other employees in the administrator's absence.

(b) Storage and Safety. Provision shall be made for the safe storage of records within the facility. Records shall be stored in a manner to reasonably protect them from water or fire damage. Records shall be safeguarded from unauthorized access.

(c) Preservation of Records. Those portions of residents' records necessary for staff to provide care, including the care plans and relevant portions of the medical examination records and admission records, shall be accessible to the direct care staff at all times. Records shall be current from the time of admission to the time of discharge or death and shall be retained in the facility for at least three years after a resident's death or discharge.

(d) Maintenance and Filing of Records and Reports.

1. All records and reports required by these rules shall be completed in a timely manner, and shall be maintained~~,~~ and filed in an orderly manner within the assisted living facility premises.

2. All entries on all records and reports shall be made by typewriter or printer or shall otherwise be written legibly using ink. Documents printed on a plain paper electronic facsimile machine shall be deemed to meet this requirement.

3. Adult Protective Services Reports. Incidents of suspected abuse, neglect, or exploitation shall be reported immediately to the Department of Human Resources or to appropriate law enforcement authorities as required by law, and shall also be reported to the Department ~~of Public Health~~ within 24 hours. Such incidents shall be immediately investigated by the facility, and the results of the investigation shall be promptly reported to the Department ~~of Public Health~~.

(e) Records Shall be Confidential. When an individual is admitted to an assisted living facility, records and information regarding the resident shall be protected from unauthorized disclosure. Employees and authorized agents of the ~~Alabama~~ Department ~~of Public Health~~ shall be permitted to review all medical records and all other records to determine compliance

with these rules. With the written consent of the resident, or with the written consent of the legal guardian of an incompetent resident, the local ombudsman shall be permitted access to all records regarding the resident. Records necessary to assess a resident's medical condition or to otherwise render good medical care shall be provided to the resident's treating physician or physicians. A resident or his or her legal guardian may grant permission to any other individual to review the resident's confidential records by signing a standard release.

(2) Administrative Records and Documents.

(a) Each assisted living facility shall maintain the following records and documents. Unless otherwise specified below, a photocopy of the record or document shall be sufficient to meet this requirement.

1. Original Articles of Incorporation or certified copies thereof, if the governing authority is incorporated, or partnership documents if the governing authority is a partnership or limited partnership.

2. A current copy of the constitution or bylaws of the governing authority, with a current roster of the membership of the governing authority.

3. Up-to-date personnel records for all employees and former employees of the facility. Personnel records for former employees shall be retained for at least three years after the employee leaves employment.

4. Current policy and procedure manual.

(b) Reports. The following reports shall be made by an assisted living facility.

1. Disease Reporting. Notifiable diseases and health conditions listed in Appendix I to Alabama Administrative *Code Sec.420-4-1-.04* shall be reported by the facility to the State Health Officer or the County Health Officer within the time frames specified in 420-4-1-.04. The facility shall also report notifiable diseases and health conditions to the Division of Health Care Facilities. The facility shall maintain documentation of any reports of notifiable diseases or health conditions. This documentation shall be retained for a period of not less than three years.

2. An assisted living facility shall conduct a thorough investigation and take appropriate corrective action in response to all reports of abuse, neglect, and exploitation of residents, and misappropriation of resident property.

Documentation of each report received, each investigation, and all corrective action taken shall be retained for a period of not less than three years.

(3) Resident Records. For each resident an assisted living facility shall maintain on its premises the seven required documents listed below and any other documents required by the facility's policies and procedures. The seven required documents are the resident's Financial Agreement, the resident's Admission Record, the resident's Medical Examination Record, the resident's Plan of Care, any Incident Report involving the resident, a Statement of Resident Rights signed by the resident, and the resident's Inventory of Personal Effects. In addition to the above seven documents, the facility shall also maintain on its premises any Advance Directive that has been executed by the resident. NOTE: under no circumstances shall the facility require a resident to execute an advance directive, nor may a facility require a resident to refrain from executing an advance directive. No staff member of the facility may encourage or discourage any resident with respect to the execution of an advance directive or contemplated execution of an advance directive. These records, either typewritten or legibly written in ink, shall be protected from unauthorized disclosure.The resident records shall be retained for a period of not less than three years after the resident is discharged or dies.

(a) Financial Agreement.

1. Prior to, or at the time of admission, the administrator and the resident or the resident's sponsor shall execute a written financial agreement. This agreement shall be prepared and signed in two or more copies with at least one copy given to the resident, or sponsor, if the resident did not sign the agreement, and one copy retained in the assisted living facility. This document shall be made readily accessible to personnel from the State Board of Health during inspections.

2. In addition to any information otherwise required by the facility's policies and procedures this agreement shall contain the following:

(i) A complete list of the facility's basic charges (room, board, laundry and personal care and services).

(ii) The period covered by the financial agreement.

(iii) A list of services not covered under basic charges and for which additional charges will be billed.

(iv) The policy and procedures for refunds of any payments made in advance.

(v) The provisions governing termination of the agreement by either party.

(vi) The facility's bed-hold policy, procedures, and charges.

(vii) Documentation that the resident and sponsor understand that the facility is not staffed and not authorized to perform skilled nursing services nor to care for residents with severe cognitive impairment and that the resident and sponsor agree that if the resident should need skilled nursing services or care for a severe cognitive impairment as a result of a condition that is expected to last for more than ninety days, that the resident will be discharged by the facility after prior written notice.

(viii) A reminder to the resident or sponsor that the local ombudsman may be able to provide assistance if the facility and the resident or family member are unable to resolve a dispute about payment of fees or monies owed.

(ix) Signatures of both parties or authorized representatives.

3. Prior to execution of the financial agreement the facility shall ensure that the resident or sponsor fully understands its provisions. In the event that a resident is unable to read the agreement due to illiteracy or infirmity, the administrator shall take special steps to assure communication of its contents to the resident (for example, by having the administrator or sponsor read the agreement to a vision-impaired or illiterate applicant).

(b) Admission Record. A permanent record shall be developed for each resident upon his or her admission to the facility. This record shall be typewritten or legibly written in ink. In addition to any information otherwise required by the facility's policies and procedures, it shall include the resident's name, date of birth, sex, marital status, social security number, and veteran status; the name, address, and telephone number of the resident's sponsor, responsible party, or closest living relative; the name, address, and telephone number of any person or agency providing assistance to the resident; the name and telephone number of the resident's attending physician; the resident's preferred pharmacy or pharmacist; the resident's date of admission and date of discharge or death; facility, setting, or location to which discharged; cause of death, if known; his or her religious preferences; and information from the resident about insurance policies (funeral arrangements and burial provisions).

(c) Medical Examination Record. Not more than thirty days prior to admission of any resident to an assisted living facility, the resident or prospective resident shall be examined by a physician, who shall report his or her findings in writing to the facility. In addition to any information otherwise required by the facility's policies and procedures, and in addition to any other information the physician believes is pertinent, the medical examination record shall contain the following:

1. All of the physician's diagnoses, and the resident's baseline weight and vital signs.

2. A statement by the physician that the resident is free of signs and symptoms of infectious skin lesions and diseases that are capable of transmission to other residents through normal resident to resident contact.

3. Medication presently prescribed (name, dosage, and strength of drug, frequency of administration).

4. A physician order is required for a resident to manage and have custody of his or her own medications.

(d) Plan of Care. There shall be a written plan of care developed for each resident prior to or at the time of admission. The plan of care shall be based on the medical examination, diagnoses, and recommendations of the resident's treating physician. The plan of care shall be developed in cooperation with the resident and, if appropriate, the sponsor. It shall document the personal care and services required from the facility by the resident. This plan shall be kept current, reviewed and updated when there is any significant change in the resident's condition, after each hospitalization, and at other appropriate times. It shall in all cases be reviewed and updated at least annually by the attending physician. In addition to other items that may be required by the facility's own policies and procedures, it shall contain the following:

1. A listing of the resident's needs or problems that require intervention by the facility, such as behavioral symptoms, weight loss, falls, and therapeutic diets. The facility shall assess the appropriateness of interventions required by each resident monthly. The facility shall on a monthly basis weigh and record the weight of each resident. The facility shall assess residents on a monthly basis and more often when necessary to identify significant changes in health status or behavior to include awareness of medication. Significant change is defined as two or more falls in 30 days or less, a significant weight loss, unmanageable or combative or potentially harmful behaviors, any adverse drug interaction or over sedation

or any elopement. A significant weight loss is defined as a 5% or greater weight loss in a period of one month or less, or a 7.5% or greater weight loss in a period of three months or less, or a 10% or greater weight loss in a period of six months or less. Any weight loss shall be considered to be an unplanned weight loss unless the affected resident has been placed on a restricted calorie diet specifically for the purpose of reducing the resident's weight, and such diet has been approved by the resident's attending physician. Any significant change requires immediate implementation and documentation of interventions or reassessment of existing interventions.

2. A description of the assistance with activities of daily living required by the resident including bathing, dressing, ambulation, feeding, toileting, grooming, medication assistance, diet and risk to personal safety. As changes in medication and personal services become necessary, the plan of care shall be promptly updated and all changes shall be documented.

3. Written documentation that the facility has devised a plan to transfer the resident to a hospital, nursing home, specialty care assisted living facility, or other appropriate setting if and when the facility becomes unable to meet the resident's needs. The resident's preference, if any, with respect to any particular hospital, nursing home, or specialty care assisted living facility shall be recorded. The facility shall keep written documentation that demonstrates the transfer plan has been thoroughly explained to the resident or sponsor, as appropriate, and that the resident or sponsor understands the transfer plan.

4. The procedure to follow in case of serious illness, accident or death to the resident (including the name and telephone number of the physician to be called, the names and telephone numbers and addresses of family members or sponsor to be contacted, the resident's or, if appropriate, the sponsor's wishes with respect to disposition of personal effects, and the name and telephone number of the funeral home to be contacted).

5. A copy of any outside provider's certification and plan of care, such as the current Home Health Certification and Plan of Care (HCFA Form 485/487) for each resident receiving care from an outside provider.

(e) For the purposes of these rules, the following terms shall have the following definitions:

1. Abuse means the willful infliction of injury, confinement, intimidation or punishment with resulting physical harm, pain, or mental anguish. Abuse shall also include verbal

abuse, sexual abuse, physical abuse, and mental abuse, as defined below.

2. Verbal abuse means the use of oral, written, or gestured language that willfully includes disparaging or derogatory terms to residents or their families, or that is used or uttered within the hearing distance of residents or their families, regardless of their age, ability to comprehend, or disability. Examples of verbal abuse include threats of harm, or saying things to frighten a resident, such as telling a resident that the resident will never see his or her family again.

3. Sexual abuse means any sexually oriented behavior directed at a resident by a staff member, any sexually oriented behavior between residents that is not fully and freely consented to by both residents involved, or any sexually oriented behavior between residents when either or both residents are incapable of consenting to the behavior because of cognitive impairment.

4. Physical abuse means any willful act directed at a resident that is intended to result in or that is likely to result in injury or pain. Physical abuse includes slapping, pinching, kicking, shoving, and corporal punishment of any kind.

5. Mental abuse means any willful act directed at a resident that is intended to result in or that is likely to result in mental distress or mental anguish. It includes humiliation, harassment, threats of punishment, and threats of deprivation.

6. Neglect means the failure to provide goods and services necessary to avoid physical harm or mental distress or anguish.

7. Exploitation means the deliberate misplacement or wrongful temporary or permanent use of a resident's belongings, money, or property without the resident's consent.

(f) Incident Investigation.

1. When an incident, as defined below, occurs in an assisted living facility, the facility administrator shall be immediately notified, the facility shall conduct an investigation, and appropriate interventions shall be devised and implemented immediately. A detailed and accurate report shall be completed within 24 hours of the incident. The report shall be given immediately upon completion to the administrator for review. The entire investigative file shall be made available for inspection and copying by representatives of the ~~Alabama~~ Department ~~of Public Health~~ upon request. The entire investigative file means the incident report itself and all

records and documents created or reviewed in connection with the investigation. Interventions devised as a result of the investigation shall be included in a resident record that is available to the personal care staff. In addition to other items required by the facility's policies and procedures, the incident report shall contain the following:

(i) Circumstances under which the incident occurred.

(ii) When the incident occurred (date and time).

(iii) Where the incident occurred (for example, bathroom, bedroom, street, or lawn).

(iv) Immediate treatment rendered.

(v) Names, telephone numbers, and addresses of witnesses.

(vi) Date and time relatives or sponsor were notified.

(vii) Out-of-facility treatment.

(viii) Symptoms of pain and injury discussed with the physician, and the date and time the physician was notified.

(ix) The extent of injury, if any, to the affected resident or residents.

(x) Follow-up care and outcome resolution.

(xi) The action taken by the facility to prevent the occurrence of similar incidents in the future.

2. Incidents which require investigation are:

(i) An accident or injury of known or unknown origin that was unusual or suspicious in nature or for which medical treatment was sought.

(ii) A fracture or an injury resulting in hospitalization;

(iii) The onset of wandering behavior by any resident who is not fully cognitively intact;

(iv) A resident who is found to be missing from the facility without staff knowledge;

(v) Sexual contact or a report of sexual contact between a resident and a staff member of the facility;

(vi) Sexual contact or a report of sexual contact between residents of the facility when such contact is not freely consented to by both residents or when one of the residents is incapable of consenting to sexual contact by reason of mental impairment;

(vii) Physical abuse, verbal abuse, emotional abuse, or a report of such abuse, directed at a resident by a staff member or visitor of the facility;

(viiii) Resident on resident physical abuse;

(ix) Theft or the reported theft of the money or personal belongings of a resident;

(x) An outbreak of a contagious disease or condition among residents (for example, influenza, methicillin resistant Staphylococcus aureus, or scabies);

(xi) A fire, earthquake, storm, other act of God or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility;

(xii) Intentional self-inflicted injury, suicide, or suicide attempt by a resident;

(xiii) An unplanned occurrence that results in media attention;

(xiv) A medication error, including overdose, that results in a resident being hospitalized;

(xv) Ingestion by a resident of a toxic substance that requires medical intervention;

(xvi) A food-borne outbreak; or

(xvii) A malfunction of the sprinkler system, or fire alarm system.

3. In addition, the following shall be reported to the ~~Assisted Living Facilities Report Faxline~~ Department's Online Incident Reporting System:

(i) A fracture or an injury resulting in hospitalization, death, EMS activation, or a visit to the emergency room.

(ii) A resident who is severely cognitively impaired who is found to be missing from the facility without staff knowledge and immediate and appropriate staff intervention;

(iii) Sexual contact or a report of sexual contact between a resident and a staff member of the facility. Sexual contact or report of sexual contact between a resident and a visitor or another resident when the sexual contact is not consensual or when the resident is incapable of consenting to sexual contact.

(iv) Physical abuse, verbal abuse, emotional abuse, or a report of such abuse, directed at a resident by a staff member or visitor of the facility and injury such as extensive bruising, pain or injury that is not consistent with actions necessary in providing day to day care to a resident;

(v) A fire, earthquake, storm, other act of God or other occurrence (for example, a natural gas leak or a bomb threat) that causes physical damage to the building in which the facility is located, or that results in the evacuation or partial evacuation of the facility;

(vi) Intentional self-inflicted injury, suicide, or suicide attempt by a resident;

(vii) An unplanned occurrence that results in media attention;

(viii) A medication error, including overdose, that results in a resident being hospitalized;

(ix) Ingestion by a resident of a toxic substance that requires medical intervention; or

(x) A malfunction of the sprinkler system, or fire alarm system.

4. The report to the ~~Assisted Living Facilities Report Faxline~~ Department's Online Incident Reporting System shall be made within 24 hours of the incident and shall include the following:

(i) Facility name and direct phone number;

(ii) Time and date of the report;

(iii) Reporter's name;

(iv) Name of resident(s), staff or visitor(s) involved in the incident;

(v) Names of staff on duty at the time of the incident;

(vi) Date and time of the incident;

(vii) Any injury or injuries to resident(s);and

(viii) Action taken by the facility in response to the incident.

(g) Residents' Rights. Each resident shall be fully informed, prior to or at the time of admission of these rights. A copy of these rights shall be conspicuously posted in a resident common area. Each resident's file shall contain a copy of a written acknowledgment that he or she has read these rights, or has had these rights fully explained by facility staff to the resident, or, if appropriate, to the resident's sponsor. The acknowledgment shall be signed and dated by the administrator or the administrator's designee and by the resident or sponsor, when appropriate.

1. No resident shall be deprived of any civil or legal rights, benefits or privileges guaranteed by law or the Constitution of the U.S. solely by reason of status as a resident of the facility.

2. Every resident shall have the right to live in a safe and decent environment, to be free from abuse, neglect, and exploitation, and to be free from chemical and physical restraints.

3. Every resident shall have the right to be treated with consideration, respect, and due recognition of personal dignity, individuality, and the need for privacy.

4. Every resident shall have the right to unrestricted private communication, including receiving and sending unopened correspondence, access to a telephone, and visiting with any person of his or her choice, at any reasonable time.

5. Every resident shall have freedom to participate in and benefit from social, religious and community services and activities and to achieve the highest possible level of independence, autonomy and interaction within the community.

6. Every resident shall have the right to manage his or her own financial affairs. If a resident or his or her legally appointed guardian authorizes the administrator of the facility to provide a safe place to keep funds on the premises, an individual account record for each resident shall be

maintained by the administrator and an up-to-date record shall be maintained for all transactions.

7. Every resident shall have the right to share a room with his spouse if both are residents of the facility and agree to do so.

8. Every resident shall have the right to reasonable opportunity for regular exercise several times a week and to be outdoors at regular and frequent intervals.

9. Every resident shall have the right to exercise civil and religious liberties, including the right to independent personal decisions. No religious beliefs or practices, nor compulsory attendance at religious services, shall be imposed upon any resident.

10. Every resident shall have access to adequate and appropriate health care consistent with established and recognized standards within the community including the right to receive or reject medical care, dental care, or other health care services except those required to control communicable diseases.

11. Every resident shall have the right to at least 30 days prior written notice of involuntary relocation or termination of residence from the facility unless for medical reasons the resident is certified by a physician to require an emergency relocation to a facility providing a more skilled level of care, or unless the resident engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents. Such actions will be documented in the resident's admission record.

12. Every resident shall have the right to present grievances and recommend changes in policies, procedures, and services to the staff of the facility, the facility's management and governing authority, and to any other person without restraint, interference, coercion, discrimination, or reprisal.

13. Every resident shall have the right to confidential treatment of personal and medical records. A resident may authorize the release of records to any individual of his or her choice. Such authorization must be given by the resident in writing and the written authorization must be included in the resident's file.

14. Every resident shall have the right to refuse to perform work or services for the facility unless the resident expressly agrees to perform such work or services and this agreement is plainly documented in the admission agreement. A resident may voluntarily perform work or services for the

facility, provided that:

(i) The facility has documented the resident's desire to perform work in the resident's plan of care, and the resident has signed this plan of care;

(ii) The plan of care specifies the nature of the work to be performed and sets forth the compensation to be paid for the service, unless the service is to be performed without compensation; and

(iii) The resident has the right and understands that he or she has the right to terminate the agreement to work at any time without recourse.

15. Every resident shall be fully informed, prior to or at the time of admission and at regular intervals during his or her stay, of services available in the facility, and of related charges.

16. Every resident shall be fully informed, as evidenced by the resident's written acknowledgment, prior to or at the time of admission, of all rules and regulations governing residents' conduct and responsibilities.

17. Every resident shall have the right to have the name, telephone number and address of the ~~Division of Health Care Facilities~~ Department's Bureau of Health Provider Standards, the Local Ombudsman, the Department of Human Resources, and the telephone numbers of the Department of Public Health toll free Assisted Living Facilities Complaint Hotline and the Department of Human Resources toll free Elder Abuse Hotline. All of this information shall be posted in a conspicuous location in a resident common area.

18. All state inspection reports and any resulting corrective action plan from the past 12 months shall be posted in a prominent location. If there has been no inspection in the past 12 months, then the results of the most recent inspection and any resulting corrective action plan, shall be posted.

19. Every resident shall have the right to 30 days prior written notice to both resident and sponsor of any increase of fees or charges.

20. Every resident shall have the right to 30 days prior written notice of any involuntary change in the resident's room or roommate unless the change is necessary because the resident or the resident's roommate engages in a pattern of conduct that is harmful or dangerous to himself or herself or to other residents.

21. Every resident shall have the right to wear his or her own clothes, to keep and use his or her own personal possessions including toilet articles except for personal possessions too large to be stored in the resident's room.

22. Every resident shall have the right to be accorded privacy for sleeping and for storage of personal belongings.

23. Every resident shall have the right to have free access to day rooms, dining and other group living or common areas at reasonable hours and to freely come and go from the home.

24. Every resident shall have the right to participate in devising the resident's care plan, including providing for the resident's preferences for physician, hospital, nursing home, acquisition of medication, emergency plans, advance directives, and funeral arrangements. A copy of this care plan shall be kept in the resident's file.

(h) Inventory of Personal Effects.

1. Upon admission to the assisted living facility, all personal property of the resident with a value in excess of $150.00, as well as any other property designated by the resident, shall be inventoried by the administrator or by a designee of the administrator in the presence of the resident.

2. All inventories shall be entered on an Inventory of Personal Effects Record. Inventory forms shall be signed by both the administrator, the resident or, if appropriate, the sponsor. One copy of the inventory shall be filed in the resident's individual file and one copy given to the resident or sponsor.

3. In the event the resident has no personal effects, this fact shall be entered on the Inventory of Personal Effects Record.

4. Amendments or adjustments shall be made on all copies of the Inventory of Personal Effects Record each time personal property valued in excess of $150.00 is brought to the facility, or when personal property is brought to the facility and the resident or sponsor requests that it be added to the Inventory of Personal Effects Record, or when any item on the Inventory of Personal Effects Record is removed from the facility. All amendments shall be signed by the administrator and the resident or sponsor.

Author: Rick Harris

Statutory Authority: Code of Ala. 1975, §§22-21-20, et seq. **History:** Filed November 20, 1991. **Repealed and New Rule:** Filed October 18, 2001; effective November 22, 2001. **Amended:** Filed June 23, 2004; effective July 28, 2004. **Amended:** Filed December 17, 2004; effective January 21, 2005. **Amended:** Filed March 21, 2007; effective April 25, 2007.