

G. When problems are identified in the provision of CRCC care, there shall be evidence of corrective actions, including ongoing monitoring, revisions of policies and procedures, educational intervention and changes in the provision of services.

H. The effectiveness of actions taken to improve services or correct identified problems shall be evaluated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.14(B).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:460 (February 2005).

§8095. Cessation of Business

A. If at any time the agency is no longer operational, the license shall be deemed to be invalid and shall be returned to DHH within five working days.

B. The agency owner shall be responsible for notifying DHH of the location of all records and a contact person.

C. In order to be operational, an agency shall:

1. have had at least 10 new patients admitted since the last annual survey;
2. be able to accept referrals at any time;
3. have adequate staff to meet the needs of their current patients;
4. have required designated staff on the premises at all times during operation;
5. be immediately available by telecommunications 24 hours per day. A registered nurse shall answer calls from patients and other medical personnel after hours; and
6. be open for the business of providing CRCC services to those who need assistance.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2175.14(B).

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 31:461 (February 2005).

Chapter 82. Minimum Standards for Licensure of Hospice Agencies

Subchapter A. General Provisions

§8201. Definitions

A. The following words and terms, when used in this Chapter, shall have the following meanings, unless the context clearly indicates otherwise:

Activities of Daily Living (ADL's)—the following functions or self-care tasks performed either independently or with supervision or assistance:

- a. mobility;
- b. transferring;
- c. walking;

- d. grooming;
- e. bathing;
- f. dressing and undressing;
- g. eating; and
- h. toileting.

Acute/General Inpatient Care—short-term, intensive hospice services provided in an appropriately licensed facility to meet the patient's need for skilled nursing, symptom management or complex medical treatment.

Advance Directives—a witnessed document, statement, or expression voluntarily made by the declarant, authorizing the withholding or withdrawal of life-sustaining procedures. A declaration may be made in writing, such as a durable power of attorney for health care, a directive pursuant to patient self-determination initiatives, a living will, or by other means of communication such as an oral directive which either states a person's choices for medical treatment or, in the event the person is unable to make treatment choices, designates who shall make those decisions.

Advanced Practice Registered Nurse (APRN)—a nurse who is legally authorized to practice advanced practice nursing in the state and designated by the patient as the licensed medical practitioner responsible for his/her medical care.

Attending/Primary Physician—a person who is a doctor of medicine or osteopathy licensed to practice medicine in the state of Louisiana, who is designated by the patient as the physician responsible for his/her medical care.

Bereavement Services—organized services provided under the supervision of a qualified professional to help the family cope with death related grief and loss issues. This shall be provided for at least one year following the death of the patient.

Branch—an alternative delivery site from which a hospice agency provides services within a portion of the total geographic area served by the parent agency. The branch office is part of the parent hospice agency and is located within a 50 mile radius of the parent agency and shares administration and supervision.

Care Giver—the person whom the patient designates to provide his/her emotional support and/or physical care.

Certified Nurse Aide (CNA) Registry—the state registry used to determine if a prospective hire who is a CNA has had a finding placed on the registry that he/she has abused or neglected a resident or misappropriated a resident's property or funds.

Cessation of Business—provider is non-operational and/or has stopped offering or providing services to the community

Chaplain—a member of the clergy.

Community—a group of individuals or a defined geographic area served by a hospice.

Continuous Home Care—care provided by the hospice during a period of crisis as necessary to maintain the terminally ill individual at home. A minimum of eight hours of care shall be furnished on a particular day to be considered continuous home care. Nursing care shall be provided for more than one half of the period of care and shall be provided by either a registered nurse or licensed practical nurse. Services may be provided by a homemaker or home health aide to supplement the nursing care. A registered nurse shall complete an assessment of the patient and determine that the patient requires continuous home care prior to assigning a licensed practical nurse, homemaker, or a hospice aide to a patient requiring continuous home care. This assignment must comply with accepted professional standards of practice.

Contracted Services—services provided to a hospice provider or its patients by a third party under a legally binding agreement that defines the roles and responsibilities of the hospice and service provider.

Core Services—nursing services, licensed medical practitioner services, medical social services, and counseling services, including bereavement counseling, dietary counseling, spiritual counseling, and any other counseling services provided to meet the needs of the individual and family. These services shall be provided by employees of the hospice, except that licensed medical practitioner services and dietary counseling services may be provided through contract. Core services also include support services, such as trained volunteers.

Department—the Department of Health (LDH).

Direct Service Worker (DSW)—an unlicensed person who provides personal care or other services and support to persons with disabilities or to the elderly to enhance their well-being, and who is involved in face-to-face direct contact with the person. Functions performed may include, but are not limited to, assistance in activities of daily living and personal care services. An example of a DSW may be a hospice or home health aide or homemaker.

Discharge—the point at which the patient's active involvement with the hospice program is ended and the program no longer has active responsibility for the care of the patient.

Do Not Resuscitate Orders—orders written by the patient's physician which stipulate that in the event the patient has a cardiac or respiratory arrest, no cardiopulmonary resuscitation will be initiated or carried out.

Emotional Support—counseling provided to assist the person in coping with stress, grief, and loss.

Employee—an individual who may be contracted, hired for a staff position or a volunteer under the jurisdiction of the hospice.

Facility-Based Care—hospice services delivered in a place other than the patient's home, such as an inpatient hospice facility, nursing facility or hospital inpatient unit.

Family—a group of two or more individuals related by ties of blood, legal status, or affection who consider themselves a family.

Geographic Area—area around location of licensed agency which is within 50 mile radius of the hospice premises. Each hospice shall designate the geographic area in which the agency will provide services.

Governing Body—the person or group of persons that assumes full legal responsibility for determining, implementing and monitoring policies governing the hospice's total operation. The governing body shall designate an individual who is responsible for the day-to-day management of the hospice program, and shall also ensure that all services provided are consistent with accepted standards of practice. Written minutes and attendance of governing body meetings are to be maintained.

Health Standards Section (HSS)—the agency within the Department of Health responsible for regulation of licensed health care providers, agencies or facilities.

Home—a person's place of residence.

Homemaker—an individual who provides light housekeeping services to patients in their homes.

Hospice—an autonomous, centrally administered, medically directed program providing a continuum of home, outpatient, and homelike inpatient care for the terminally ill patient and his family. It employs an interdisciplinary team to assist in providing palliative and supportive care to meet the special needs arising out of the physical, emotional, spiritual, social, and economic stresses which are experienced during the final stages of illness and during dying and bereavement.

Hospice Inpatient Facility—a facility where specific levels of hospice care ranging from residential to acute, including respite, are provided in order to meet the needs of the patient/family.

Hospice Inpatient Services—care and services available for pain control, symptom management and/or respite purposes that are provided for a patient either directly by the hospice agency or in a participating facility.

Hospice Physician—a person who is a doctor of medicine or osteopathy, and is currently and legally authorized to practice medicine in the State of Louisiana, designated by the hospice to provide medical care to hospice patients in lieu of their primary licensed medical practitioner.

Hospice Premises—the physical site where the hospice maintains staff to perform administrative functions, and maintains its personnel records, or maintains its patient service records, or holds itself out to the public as being a location for receipt of patient referrals.

Hospice Services—a coordinated program of palliative and supportive care, in a variety of appropriate settings, from the time of admission through bereavement, with the focus on keeping terminally ill patients in their place of residence as long as possible.

Informed Consent—a documented process in which information regarding the potential and actual benefit and risks of a given procedure or program of care is exchanged between provider and patient.

Interdisciplinary Team (IDT)—an interdisciplinary team or teams designated by the hospice, composed of representatives from all the core services. The IDT shall include at least a doctor of medicine or osteopathy, a registered nurse, a social worker, a pastoral or other counselor, and a representative of the volunteer services. The interdisciplinary team is responsible for participation in the establishment of the plan of care; provision or supervision of hospice care and services; periodic review and updating of the plan of care for each individual receiving hospice care, and establishment of policies governing the day-to-day provision of hospice care and services. If a hospice has more than one interdisciplinary team, it shall designate in advance the team it chooses to execute the establishment of policies governing the day-to-day provision of hospice care and services.

Interdisciplinary Team Conferences—regularly scheduled periodic meetings of specific members of the interdisciplinary team to review the most current patient/family assessment, evaluate care needs, and update the plan of care.

Louisiana At-Risk Registry—the reporting mechanism for hospice patients that require community assistance in emergency situations.

Louisiana Physician Order for Scope of Treatment (LaPOST)—a physician's order that documents the wishes of a qualified patient for life-sustaining interventions, as well as the patient's preferred treatment for each intervention, on a form that is recognized, adopted, and honored across treatment settings in accordance with state laws.

Major Alteration—any repair or replacement of building materials and equipment which does not meet the definition of minor alteration.

Medical Social Services—include a comprehensive psychosocial assessment; ongoing support for the patient and family; and assistance with coping skills, anticipatory grief, and grief reactions.

Minor Alteration—repair or replacement of building materials and equipment with materials and equipment of a similar type that does not diminish the level of construction below that which existed prior to the alteration. This does not include any alteration to the function or original design of the construction.

Non-Core Services—services provided directly by hospice employees or under arrangement. These services include, but are not limited to:

- a. hospice aide and homemaker;
- b. physical therapy services;
- c. occupational therapy services;
- d. speech-language pathology services;

e. inpatient care for pain control and symptom management and respite purposes; and

f. medical supplies and appliances including drugs and biologicals.

Non-Operational—the hospice agency location is not open for business operation on designated days and hours as stated on the licensing application and business location signage.

Palliative Care—the reduction or abatement of pain or other troubling symptoms by appropriate coordination of all services of the hospice care team required to achieve needed relief of distress.

Period of Crisis—a period in which a patient requires predominately nursing care to achieve palliation or management of acute medical problems.

Plan of Care (POC)—a written document established and maintained for each individual admitted to a hospice program. Care provided to an individual shall be in accordance with the plan. The plan includes an assessment of the individual's needs and identification of the services including the management of discomfort and symptom relief.

Public Health Emergency (PHE)—a declaration made pursuant to the Louisiana Health Emergency Powers Act, R.S. 29:760 et seq.

Representative—an individual who has been authorized under State law to terminate medical care or to elect or revoke the election of hospice care on behalf of a terminally ill individual who is mentally or physically incapacitated.

Residential Care—hospice care provided in a nursing facility, adult residential facility or any residence or facility other than the patient's private residence.

Respite Care—short-term care generally provided in a nursing facility or hospice facility to provide relief for the family from daily care of the patient.

Spiritual Services—providing the availability of clergy as needed to address the patient's/family's spiritual needs and concerns.

State Certified Hospice Attendant—a former inmate of a Louisiana state prison with a hospice provider license issued by the Department of Health who shall be eligible to be employed as a non-licensed person by a provider licensed to provide hospice services pursuant to the requirements of R.S. 40:2192 if the following provisions are satisfied:

- a. the former inmate shall not have been convicted of a sex offense as defined by R.S. 27 15:541;
- b. while incarcerated, the former inmate shall have been a caregiver in the licensed hospice program, with documentation of such, and successfully completed the training pursuant to subsection B of R.S.40:2192;
- c. the former inmate shall hold a certification issued by the Department of Public Safety and Corrections;

d. the former inmate shall submit notice of his/her certification to the department in a manner prescribed by the Department of Health; and

e. there are no federal restrictions or prohibitions against the former inmate providing hospice services.

Sublicense—a license issued for the inpatient hospice facility that provides inpatient hospice services directly under the operation and management of the licensed hospice entity.

Terminally Ill—a medical prognosis of limited expected survival, of approximately six months or less at the time of referral to a hospice, of an individual who is experiencing an illness for which therapeutic strategies directed toward cure and control of the disease alone are no longer appropriate. Therapeutic strategies by the hospice agency are directed toward pain and symptom management of the terminal illness.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2181-2192.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2257 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:588 (March 2018), LR 46:344 (March 2020), LR 47:1307 (September 2021).

§8203. Licensing

A. Except to the extent required by §8205.A.1, it shall be unlawful to operate or maintain a hospice without first obtaining a license from the department. The Department of Health is the only licensing authority for hospice in the state of Louisiana.

B. A separately licensed hospice may not use a name which is substantially the same as the name of another hospice licensed by the department unless the agency is part of a corporation or is chain affiliated.

C. Issuance of a License. The licensing agency shall have authority to issue two licenses as described below.

1. Full license is issued only to those agencies that are in substantial compliance with applicable federal, state, and local laws. The license shall be valid until the expiration date shown on the license.

2. Provisional license is issued to those existing licensed agencies which do not meet criteria for Full licensure. The license shall be valid for six months or until termination date.

a. At the sole discretion of the department, the provisional license may be extended for a period of time, not to exceed 90 days, in order for the facility to correct the noncompliance or deficiencies.

b. An agency with a provisional license may be issued a full license, if at the follow-up survey the agency has corrected the violations. A full license will be issued for the remainder of the year until the hospice agency's license anniversary date.

c. LDH may re-issue a provisional license or allow a provisional license to expire when the hospice fails to correct violations within 60 days of being cited, or at the time of the follow-up survey, whichever occurs first.

d. A provisional license may be issued by LDH for the following non-exclusive reasons:

i. agency has more than five violations of hospice regulations during one survey;

ii. agency has more than three valid complaints in a one year period;

iii. there is a documented incident that places a patient at risk;

iv. agency fails to correct violations within 60 days of being cited, or at the time of a follow-up survey, whichever occurs first;

v. agency has an inadequate referral base, other than at the time of the initial survey for licensure, has less than 20 new patients admitted since the last annual survey.

e. Agency fails to submit assessed fees after notification by LDH.

f. Documented evidence that agency has bribed, or harassed any person to use the services of any particular hospice agency.

D. Display of License. The current license shall be displayed in a conspicuous place inside the hospice program office at all times. A license shall be valid only in the possession of the agency to which it is issued. A license shall not be subject to sale, assignment, or other transfer, voluntary or involuntary. A license shall not be valid for any hospice other than the hospice for which originally issued. If an agency has been issued a sublicense for its hospice inpatient facility, both license and sublicense shall be displayed.

E. Initial Licensure. All requirements of the application process shall be completed by the applicant before the application will be processed by LDH. Each hospice applicant shall obtain facility need review approval prior to submission of initial licensing application.

1. No application will be reviewed until the application fee is received.

2. An initial applicant shall, as a condition of licensure, submit the following:

a. a complete and accurate hospice application packet. (This packet may be printed from the LDH-Hospice webpage or may be purchased from LDH-HSS and contains the forms required for initial hospice licensure. The address provided on the application shall be the address from which the agency will be operating;

b. current required licensing fee by certified check, company check, or money order;

NOTE: Payment of any fees shall be submitted to the department's required payment source.

c. line of credit from a federally insured, licensed, lending agency for at least \$75,000 as proof of adequate finances to sustain the hospice agency for at least six months;

d. proof of general and professional liability insurance, and worker's compensation of at least \$300,000. The certificate holder shall be the Department of Health;

e. documentation of qualifications for administrator, director of nursing, and medical director. Any changes in the individuals designated or in their qualifications shall be submitted to and approved by LDH prior to the initial survey;

f. disclosure of any financial and/or familial relationship with any other entity receiving third party payor funds, or any entity which has previously been licensed in Louisiana;

g. proof of statewide criminal background investigations conducted by the Louisiana State Police, or its designee, on the administrator and all owners. If a corporation, submit proof of statewide criminal background investigations conducted by the Louisiana State Police, or its designee, on all board of directors and principal owners; and

h. if the hospice agency is also applying for an inpatient facility, then an 8 1/2 x 11 inch drawing of the physical plant shall be submitted and any other documentation requested by the department for licensure of the agency.

F. Denial of Initial Licensure. An applicant may be denied an initial license for the following reasons:

1. failure to comply with applicable federal, state, and local laws;
2. failure to complete the application process;
3. conviction of a felony by an owner, administrator, or director of nursing, as shown by a certified copy of the record of the court, of the conviction of the above individual; or if the applicant is a firm or corporation, conviction of any of its members or officers, or of the person(s) designated to manage or supervise the Hospice agency.

G. Provisional Initial Licensure. In the event that the initial licensing survey finds that the hospice agency is noncompliant with any licensing laws, rules or regulations, the department, in its sole discretion, may determine that the noncompliance does not present a threat to the health, safety, or welfare of the patients, and may issue a provisional initial license for a period not to exceed six months.

1. The provider shall be required to correct all such noncompliance or deficiencies prior to the expiration of the provisional license.

a. If all such noncompliance or deficiencies are determined by the department to be corrected on a follow-up survey, a full license shall be issued.

b. If all such noncompliance or deficiencies are not corrected on the follow-up survey, the provisional license

shall expire and the provider shall be required to begin the initial licensing process again by submitting a new application packet and fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2259 (December 1998), LR 25:2409 (December 1999), amended by the Department of Health, Bureau of Health Services Financing, LR 44:590 (March 2018).

§8205. Survey

A. Initial Survey. An initial on-site survey will be conducted to assure compliance with all hospice minimum standards.

1. Within 90 days after submitting its application and fee, the hospice shall complete the application process, shall become operational to the extent of providing care to only two outpatients, shall be in substantial compliance with applicable federal, state, and local laws, and shall be prepared for the initial survey. If the applicant fails to meet this deadline, the application shall be considered closed and the agency shall be required to submit a new application packet including the license application fee.

2. The hospice agency that applies for an inpatient facility license shall not provide care to patients in the agency's inpatient hospice facility setting prior to the initial survey and achieving inpatient facility licensure.

3. The initial survey will be scheduled after the agency notifies the department that the agency had become operational and is ready for the survey as provided in §8205.A.1.

4. If, at the initial licensing survey, the agency is in substantial compliance with all regulations, a full license will be issued.

5. If, at the initial licensure survey, an agency has more than five violations of any minimum standards or if any of the violations are determined to be of such a serious nature that they may cause or have the potential to cause actual harm, LDH shall deny licensing.

B. Licensing Survey. An unannounced on-site visit, or any other survey, which may include home visits, may be conducted periodically to assure compliance with all applicable federal, state, and local laws and/or any other requirements.

C. Follow-up Survey. An on-site follow-up may be conducted whenever necessary to assure correction of violations. When applicable, LDH may clear violations at exit interview and/or by documentation review.

D. Statement of Deficiencies

1. The department shall issue written notice to the agency of the results of any surveys in a statement of deficiencies, along with notice of specified timeframe for a plan of correction, if appropriate.

2. Any statement of deficiencies issued by the department to a hospice agency shall be available for disclosure to the public 30 calendar days after the agency submits an acceptable plan of correction of the deficiencies or 90 calendar days after the statement of deficiencies is issued to the agency, whichever occurs first.

E. Complaint Investigations

1. The department shall conduct complaint investigations in accordance with R.S. 40:2009.13 et seq.

2. Complaint investigations shall be unannounced.

3. Upon request by the department, an acceptable plan of correction shall be submitted by the agency for any complaint investigation where deficiencies have been cited. Such plan of correction shall be submitted within the prescribed timeframe.

4. A follow-up survey may be conducted for any complaint investigation where deficiencies have been cited to ensure correction of the deficient practices.

5. The department may issue appropriate sanctions, including but not limited to, civil fines, directed plans of correction, provisional licensure, denial of license renewal, and license revocation for non-compliance with any state law or regulation.

6. The department's surveyors and staff shall be given access to all areas of the hospice agency and all relevant files during any complaint investigation. The department's surveyors and staff shall be allowed to interview any agency staff or patient as necessary or required to conduct the investigation.

F. Unless otherwise provided in statute or in this Chapter, the hospice agency shall have the right to an informal reconsideration for any deficiencies cited as a result of a survey or an investigation.

1. Correction of the deficient practice, of the violation, or of the noncompliance shall not be the basis for the reconsideration.

2. The informal reconsideration of the deficiencies shall be submitted in writing within 10 calendar days of receipt of the statement of deficiencies, unless otherwise provided for in these provisions.

3. The written request for informal reconsideration of the deficiencies shall be submitted to the Health Standards Section.

4. Except as provided for complaint surveys pursuant to R.S. 40:2009.11 et seq., and as provided in this Chapter for license denials, revocations, and denial of license renewals, the decision of the informal reconsideration team shall be the final administrative decision regarding the deficiencies. There is no administrative appeal right of such deficiencies.

5. The agency shall be notified in writing of the results of the informal reconsideration.

6. The request for an informal reconsideration of any deficiencies cited as a result of a survey or investigation does not delay submission of the required plan of correction within the prescribed timeframe.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR:15:482 (June 1989), amended LR 24:2260 (December 1998), LR 25:2409 (December 1999), LR 29:2800 (December 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 44:591 (March 2018).

§8207. Revocation or Denial of Initial License or Renewal of License

A. The secretary of LDH may deny an application for a license, or refuse to renew a license or revoke a license in accordance with R.S. 40:2187-2188. An agency's license may not be renewed and/or may be revoked for any of the following:

1. failure to be in substantial compliance with the hospice minimum standards;

2. failure to provide services essential to the palliative care of terminally ill individuals;

3. failure to uphold patient rights whereby violations may result in harm or injury;

4. failure of agency to protect patients/persons in the community from harmful actions of the agency employees; including, but not limited to, health and safety, coercion, threat, intimidation, and harassment;

5. failure to notify proper authorities of all suspected cases of neglect, criminal activity, or mental or physical abuse which could potentially cause harm to the patient;

6. failure to maintain staff adequate to provide necessary services to current active patients;

7. failure to employ qualified personnel;

8. failure to submit fees including, but not limited to, annual fee, renewal fee, provisional follow-up fee, or change of agency address or name, or any fines assessed by LDH;

9. failure to allow surveyors entry to hospice agency or access to any requested records during any survey;

10. failure to protect patient from unsafe skilled and/or unskilled care by any person employed or contracted by the agency;

11. agency staff or owner has knowingly, or with reason to know, made a false statement of a material fact in:

a. application for licensure;

b. data forms;

c. clinical record;

d. matter under investigation by the department;

e. information submitted for reimbursement from any payment source;

f. the use of false, fraudulent or misleading advertising;

g. that the agency staff misrepresented or was fraudulent in conducting hospice business; or

h. convictions of a felony by an owner, administrator, director of nursing or medical director as shown by a certified copy of the record of the court of conviction of the above individual; or if the applicant is a firm or corporation, of any of its members or officers, or of the person designated to manage or supervise the hospice agency;

12. failure to maintain proper insurance; or

13. failure to comply with all reporting requirements in a timely manner.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2260 (December 1998), LR 29:2800 (December 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 44:592 (March 2018).

§8209. License Renewal Process

A. License shall be renewed annually.

B. Renewal packet includes forms required for renewal of license.

C. An agency seeking a renewal of its hospice license shall:

1. request a renewal packet from HSS if one is not received at least 45 days prior to license expiration;

2. complete all forms and return to HSS at least 30 days prior to license expiration;

3. submit the current annual licensure fees with packet. An application is not considered to have been submitted unless the required licensure fees are received.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2261 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:592 (March 2018).

§8211. Notice and Appeal Procedure for Revocation of Licensure and Denial of Initial License or License Renewal

A. Notice shall be given in accordance with the current State Statutes.

B. Administrative Reconsideration

1. The hospice agency may request an administrative reconsideration of the violation(s) which support the department's actions.

a. The request for reconsideration shall be made, and received by the department, within 15 calendar days of receipt of notice.

2. The reconsideration shall be conducted by a designated official(s) of the department who did not participate in the initial decision to impose the actions taken.

a. Reconsideration shall be made solely on the basis of documents before the official and shall include the survey report and statement of violations, and all documentation the agency submits to the department at the time of the agency's request for reconsideration.

b. Oral presentations may be made by the department's spokesperson(s) and the agency's spokesperson(s).

c. The designated official shall have authority only to affirm the decision, to revoke the decision, to affirm part and revoke part, or to request additional information from either the department or the agency.

3. Correction of a violation shall not be a basis for reconsideration.

4. This process is not in lieu of the appeals process and may extend the time limits for filing an administrative appeal.

C. Administrative Appeal Process

1. Upon refusal of LDH to grant or renew a license as provided in the current state statutes, or upon revocation or suspension of a license, or the imposition of a fine, the affected agency, institution, corporation, person, or other group shall have the right to appeal such action by submitting a written request to the Division of Administrative Law (DAL) or its successor:

a. within 30 days after receipt of the notification of the refusal, revocation, suspension of a license, or imposition of a fine; or

b. within 30 days after receipt of the notification of the results of the administrative reconsideration of the department's action.

2. Hearings shall be conducted by the DAL in accordance with the Administrative Procedure Act (APA).

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2261 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:592 (March 2018).

§8213. Fees

A. Any remittance submitted in payment of a required fee shall be in the form of a company or certified check or money order made payable to the "Louisiana Department of Health".

B. Fee amounts are determined by LDH. (Check with LDH to determine the current required fees.)

C. Fees paid to LDH are not refundable.

D. A licensing fee is required for:

1. an initial application;
2. a renewal;
3. a change of controlling ownership; and
4. a change of location.

E. Additional licensure fees are required for inpatient hospice facilities which includes the required licensing fee and per unit fee.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2261 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:593 (March 2018).

§8215. Changes

A. LDH shall be notified, in writing, of any of the following within five working days following the occurrence:

1. address/location (an inpatient hospice facility shall notify and receive approval by LDH prior to a change of address/location)—fee required;
2. agency name - fee required;
3. phone number;
4. hours of operation/24 hour contact procedure;
5. ownership (Controlling) - fee required;
6. change in address of any branch office—fee required;
7. administrator (completed key personnel change form, obtained from LDH required);
8. director of nursing (completed key personnel change form required); or
9. cessation of business in accordance with the requirements of §8243.

B. Change of Ownership. A representative of the buyer shall request approval for a change of ownership prior to the sale.

1. Submit a written notice to LDH for a change of ownership. Change of ownership (CHOW) packets may be obtained from LDH. If the hospice had less than two active patients at the time of the most recent survey, and less than twenty new patients admitted since the last annual survey, the department may have issued a provisional license. Only an agency with a full license shall be approved to undergo a change of ownership.

2. Submit the following documents for a CHOW:

a. a new license application and the current licensing fee. The purchaser of the agency shall meet all

criteria required for initial licensure for hospice in accordance with the provisions of §8203;

- b. any changes in the name and or address of the agency;
- c. any changes in administrative personnel;
- d. disclosure of ownership forms; and
- e. a copy of the bill of sale and articles of incorporation.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2262 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:593 (March 2018).

§8216. Emergency Preparedness

A. The hospice shall annually conduct and document an all hazard vulnerability or risk assessment for the agency's patients, both outpatient and inpatient.

B. The hospice shall develop an emergency responsiveness plan based on the risk assessment, inclusive of the following but not limited to:

1. preparation for evacuation;
2. training of employees;
3. patient and caregiver education and individual preparedness;
4. tracking of staff and patients;
5. communication and chain of command;
6. sheltering in place; and
7. coordination with local and state emergency operation offices.

C. The hospice shall update the "Louisiana at-risk registry" or other current state-required reporting mechanism as needed based on the following hospice patient criteria:

1. patients who live alone, without a caregiver and are unable to evacuate themselves;
2. patients with a caregiver physically or mentally incapable of carrying through on an evacuation order;
3. patients/caregivers without the financial means to carry through on an evacuation order; or
4. patients/caregivers refusing to evacuate.

D. The governing body shall be responsible to develop and annually review and document approval of the hospice agency's emergency plans, policies and procedures.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 44:593 (March 2018).

Subchapter B. Organization and Staffing

§8217. Personnel Qualifications/Responsibilities

A. *Administrator*—a person who is designated, in writing, by the governing body as administratively responsible for all aspects of hospice operations. When the administrator serves more than one licensed agency, he/she shall designate, in writing, an alternate to serve as administrator for each site where he/she is not physically housed continuously. The administrator may not serve more than two licensed agencies. The alternate shall be a full-time, on-site employee of the hospice and shall meet the same qualifications as the administrator. The administrator and the director of nurses/alternates may be the same individual if that individual is dually qualified.

1. *Qualifications.* The administrator shall be a licensed physician, a licensed registered nurse, a social worker with a master's degree, or a college graduate with a bachelor's degree and at least three years of documented management experience in health care service delivery. However, a person who was employed by a licensed Louisiana hospice as the administrator as of December 20, 1998 shall be exempt from these requirements as long as he/she remains employed by that hospice as the administrator. If the hospice is sold to, acquired by, or merged into another legal entity, such transaction shall have no effect on the exemption provided in the preceding sentence.

2. *Responsibilities.* The Administrator shall be responsible for compliance with all regulations, laws, policies and procedures applicable to hospice specifically and to Medicare/Medicaid issues when applicable:

- a. ensure the hospice employs qualified individuals;
- b. be on-site during business hours or immediately available by telecommunications when off-site conducting the business of the hospice, and available after hours as needed;
- c. be responsible for and direct the day-to-day operations of the hospice;
- d. act as liaison among staff, patients, and governing board;
- e. ensure that all services are correctly billed to the proper payer source;
- f. designate, in writing, an individual who meets the administrator qualifications to assume the authority and the control of the hospice if the administrator is unavailable; and
- g. designate in advance the IDT he/she chooses to establish policies governing the day-to-day provisions of hospice care.

3. *Continuing Education.* The administrator shall annually obtain two continuing education hours relative to the administrator's role, including but not limited to the following topics:

- a. Medicare and Medicaid regulations;
- b. management practices;
- c. labor laws; and
- d. Occupational Safety and Health Administration rules, laws, etc.

B. Counselor—Bereavement

1. *Qualifications.* Documented evidence of appropriate training, and experience in the care of the bereaved received under the supervision of a qualified professional.

2. *Responsibilities.* Under the supervision of a qualified professional, and as part of an organized program for the provision of bereavement services, the counselor shall implement bereavement counseling in a manner consistent with standards of practice. Services include, but are not limited to the following:

- a. assess grief counseling needs;
- b. provide bereavement information and referral services to the bereaved, as needed, in accordance with the POC;
- c. provide bereavement support to hospice staff as needed;
- d. attend hospice IDT meetings; and
- e. document bereavement services provided and progress of bereaved on a clinical progress note to be incorporated into the clinical record.

3. *Continuing Education.* The bereavement counselor shall annually obtain two continuing education hours relative to the bereavement counselor's role, including but not limited to the following topics:

- a. death and dying cultures;
- b. suicide;
- c. compassion fatigue;
- d. anticipatory grief;
- e. patient survivors;
- f. grief groups;
- g. grief;
- h. loss;
- i. adjustment;
- j. ethics; and
- k. advanced directives and LaPOST.

C. Counselor—Dietary

1. *Qualifications.* A registered dietician or person who meets the qualification standards of the Commission on Dietetic Registration of the American Dietetic Association.

2. Responsibilities. The dietitian shall implement dietary services based on initial and ongoing assessment of dietary needs in a manner consistent with standards of practice including, but not limited to, the following:

a. evaluate outcomes of interventions and document findings on a clinical progress note which is to be incorporated into the clinical record within one week of the visit;

b. collaborate with the patient/family, physician, registered nurse, and/or the IDT in providing dietary counseling to the patient/family;

c. instruct patient/family and/or hospice staff as needed;

d. evaluate patient socioeconomic factors to develop recommendations concerning food purchasing, preparation and storage;

e. evaluate food preparation methods to ensure nutritive value is conserved, flavor, texture and temperature principles are adhered to in meeting the individual patient's needs;

f. participate in IDT conference as needed; and

g. be an employee of the hospice agency.

D. Counselor—Spiritual

1. Qualifications. Documented evidence of appropriate training and skills to provide spiritual counseling, such as bachelor of divinity, master of divinity or equivalent theological degree or training from an accredited school or university. An individual may qualify as a spiritual counselor without said degree if he/she has documented skills to provide spiritual counseling and has received equivalent training and supervision from an individual who meets one of the above qualifications.

2. Responsibilities. The counselor shall provide spiritual counseling based on the initial and ongoing assessment of spiritual needs of the patient/family, in a manner consistent with standards of practice including, but not limited to, the following:

a. serve as a liaison and support to community chaplains and/or spiritual counselors;

b. provide consultation, support, and education to the IDT members on spiritual care;

c. supervise spiritual care volunteers assigned to family/care givers; and

d. attend IDT meetings.

3. Continuing Education. The spiritual counselor shall annually obtain at least two hours of continuing education related to the following topics, including but not limited to:

a. end of life care;

b. cultural religious practices;

c. compassion fatigue;

d. suicide;

e. documentation;

f. ethics;

g. grief;

h. loss;

i. adjustment; and

j. advanced directives and LaPOST.

E. *Director of Nurses (DON)*—a person designated, in writing, by the governing body to supervise all aspects of patient care, all activities of professional staff and allied health personnel, and responsible for compliance with regulatory requirements. The DON, or alternate, shall be immediately available to be on site, or on site, at all times during operating hours, and additionally as needed. If the DON is unavailable he/she shall designate a registered nurse to be responsible during his/her absence.

1. Qualifications. A registered nurse shall be currently licensed to practice in the state of Louisiana:

a. with at least three years' experience as a registered nurse. One of these years shall consist of full-time experience in providing direct patient care in a hospice, home health, or oncology setting; and

b. be a full time, salaried employee of only the hospice agency. The Director of Nurses is prohibited from simultaneous/concurrent employment. While employed by the hospice, he or she may not be employed by any other licensed health care agency.

2. Responsibilities. The registered nurse shall supervise all patient care activities to assure compliance with current standards of accepted nursing and medical practice including, but not limited to, the following:

a. the POC;

b. implement personnel and employment policies to assure that only qualified personnel are hired. Verify licensure and/or certification (as required by law) prior to employment and annually thereafter; maintain records to support competency of all allied health personnel;

c. implement hospice policies and procedures that establish and support quality patient care, cost control, and mechanisms for disciplinary action for infractions;

d. supervise employee health program;

e. assure compliance with local, state, and federal laws, and promote health and safety of employees, patients and the community, using the following non-exclusive methods:

i. resolve problems;

ii. perform complaint investigations;

iii. refer impaired personnel to proper authorities;

iv. provide for orientation and in-service training to employees to promote effective hospice services and

safety of the patient, to familiarize staff with regulatory issues, and agency policy and procedures;

- v. orient new direct health care personnel;
- vi. perform timely annual evaluation of performance of health care personnel;
- vii. assure participation in regularly scheduled appropriate continuing education for all health professionals and hospice aides and homemakers;
- viii. assure that the care provided by the health care personnel promotes effective hospice services and the safety of the patient; and
- ix. assure that the hospice policies are enforced.

F. Governing Body

1. The hospice shall have a governing body that assumes full legal responsibility for determining, implementing and monitoring policies governing the hospice's total operation, inclusive of any inpatient hospice services.

2. No contracts/arrangements or other agreements may limit or diminish the responsibility of the governing body.

3. The governing body shall:

- a. designate an individual who is responsible for the day to day management of the hospice program;
- b. ensure that all services provided are consistent with accepted standards of practice;
- c. develop and approve policies and procedures which define and describe the scope of services offered;
- d. review policies and procedures at least annually and revise them as necessary; and
- e. maintain an organizational chart that delineates lines of authority and responsibility for all hospice personnel.

G. Hospice Aide/Homemaker. A qualified person who provides direct patient care and/or housekeeping duties in the home or homelike setting under the direct supervision of a registered nurse.

1. Qualifications. The hospice aide/homemaker shall meet one of the training requirements listed in §8217.G.1.a-c and shall meet all other requirements of §8217.G.1.d-g:

- a. have current certified hospice and palliative nursing assistant (CHPNA) certification and have successfully completed a hospice aide competency evaluation; or
- b. have successfully completed a hospice aide training program and have successfully completed a competency evaluation; or
- c. have successfully completed a hospice aide competency evaluation; and

d. exhibit maturity, a sympathetic attitude toward the patient, ability to provide care to the terminal patient, and ability to deal effectively with the demands of the job;

e. have the ability to read, write, and carry out directions promptly and accurately;

f. competency shall be evaluated by a RN prior to hospice aide performing patient care; and

g. when employed by more than one agency, inform all employers and coordinate duties to assure highest quality when providing services to the patients; and

NOTE: The hospice aide competency evaluation is to be completed by a registered nurse prior to the hospice aide being assigned to provide patient care.

h. shall not have a finding of abuse, neglect or misappropriation placed against him/her on the Louisiana direct service worker (DSW) registry or the Louisiana certified nurse side (CNA) registry.

2. Responsibilities. The hospice aide/homemaker shall provide services established and delegated in the POC, record and notify the primary registered nurse of deviations according to standard practice including, but not limited to, the following:

a. perform simple one-step wound care if written documentation of in-service for that specific procedure is in the aide's personnel record. All procedures performed by the aide shall be in compliance with current standards of nursing practice

b. provide assistance with mobility, transferring, walking, grooming, bathing, dressing or undressing, eating, toileting, and/or housekeeping needs. Some examples of assistance include:

- i. helping the patient with a bath, care of the mouth, skin and hair;
- ii. helping the patient to the bathroom or in using a bed pan or urinal;
- iii. helping the patient to dress and/or undress;
- iv. helping the patient in and out of bed, assisting with ambulating;

v. helping the patient with prescribed exercises which the patient and hospice aide have been taught by appropriate personnel; and

vi. performing such incidental household services essential to the patient's health care at home that are necessary to prevent or postpone institutionalization;

d. complete a clinical note for each visit, which shall be incorporated into the record at least on a weekly basis.

3. Restrictions. The hospice aide/homemaker shall not:

a. perform any intravenous procedures, procedures involving the use of Levine tubes or Foley catheters, or any

other sterile or invasive procedures, other than rectal temperatures or enemas;

b. administer medications to any patient.

4. Initial Orientation. The content of the basic orientation provided to hospice aides shall include the following:

a. policies and objectives of the agency;

b. duties and responsibilities of a hospice aide/homemaker;

c. the role of the hospice aide/homemaker as a member of the health care team;

d. emotional problems associated with terminal illness;

e. the aging process;

f. information on the process of aging and behavior of the aged;

g. information on the emotional problems accompanying terminal illness;

h. information on terminal care, stages of death and dying, and grief;

i. principles and practices of maintaining a clean, healthy and safe environment;

j. ethics; and

k. confidentiality.

NOTE: The orientation and training curricula for hospice aides/homemakers shall be detailed in a policies and procedures manual maintained by the hospice agency and provision of orientation and training shall be documented in the employee personnel record.

5. Initial training shall include the following areas of instruction for personal care and support:

a. assisting patients to achieve optimal activities of daily living;

b. principles of nutrition and meal preparation;

c. record keeping;

d. procedures for maintaining a clean, healthful environment;

e. changes in the patients' condition to be reported to the supervisor;

f. confidentiality;

g. patients' rights and responsibilities; and

h. emergency preparedness.

6. In-Service Training. Hospice aide/homemaker shall have a minimum of 12 hours of job-related in-service training annually specific to their job responsibilities within the previous 12 months:

a. at least two hours shall focus on end of life care annually; and

b. six of the twelve hours of job-related in service training shall be provided every six months.

7. In-service training may be prorated for employees working a portion of the year. However, part-time employees who worked throughout the year shall attend all 12 hours of in-service training. The in-service may be furnished while the aide is providing service to the patient, but shall be documented as training.

H. Licensed Practical Nurse (LPN). The LPN shall work under the direct supervision of a registered nurse (RN) and perform skilled nursing services as delegated by the RN. The role of the LPN in hospice is limited to stable hospice patients.

1. Qualifications. An LPN shall be currently licensed by the Louisiana State Board of Practical Nurse Examiners with no restrictions:

a. with at least two years of full time experience as an LPN;

EXCEPTION: The requirement in 1.a is waived for any LPN that becomes employed by a hospice provider during a declared public health emergency (PHE) which extends statewide and continues for more than 90 consecutive days. Any LPN hired under this exception may continue to be employed by the same hospice provider after the PHE is over.

b. be an employee of the hospice agency; and

c. when employed by more than one agency the LPN shall inform all employers and coordinate duties to assure quality provision of services.

2. Responsibilities. The LPN shall perform skilled nursing services under the supervision of an RN, in a manner consistent with standards of practice, including but not limited to, such duties as follows:

a. observe, record, and report to the RN or director of nurses on the general physical and mental conditions of the patient;

b. administer prescribed medications and treatments as permitted by State or Local regulations;

c. assist the physician and/or RN in performing specialized procedures;

d. prepare equipment for treatments, including sterilization, and adherence to aseptic techniques;

e. assist the patient with activities of daily living;

f. prepare clinical and/or progress notes and incorporate them into the clinical record at least weekly;

g. perform complex wound care if in-service is documented for specific procedure;

h. perform routine venipuncture (phlebotomy) if written documentation of competency is in personnel record. Competency shall be evaluated by an RN even if LPN has completed a certification course; and

i. receive orders from the licensed medical practitioner and follow those that are within the realm of

practice for an LPN and within the standards of hospice practice.

3. Restrictions. An LPN shall not:

- a. access any intravenous appliance for any reason;
- b. perform supervisory aide visit;
- c. develop and/or alter the POC;
- d. make an assessment visit;
- e. evaluate recertification criteria;
- f. make aide assignments;
- g. function as a supervisor of the nursing practice of any RN; or
- h. function as primary on-call nurse.

I. Medical Director/Physician Designee and Advanced Practice Registered Nurse

1. The medical director/physician designee shall be a physician, currently and legally authorized to practice in the state, and knowledgeable about the medical and psychosocial aspects of hospice care. The medical director reviews, coordinates, and is responsible for the management of clinical and medical care for all patients, inclusive of any inpatient hospice patient.

NOTE: The medical director or physician designee may be an employee or a volunteer of the hospice agency. The hospice agency may also contract for the services of the medical director or physician designee.

a. Qualifications. A doctor of medicine or osteopathy licensed to practice in the state of Louisiana.

b. Responsibilities. The medical director or physician designee assumes overall responsibility for the medical component of the hospice's patient care program and shall include, but not be limited to:

- i. serve as a consultant with the attending physician regarding pain and symptom control as needed;
- ii. serve as the attending physician if designated by the patient/family unit;
- iii. review patient eligibility for hospice services;
- iv. serve as a medical resource for the hospice interdisciplinary team;
- v. act as a liaison to physicians in the community;
- vi. develop and coordinate procedures for the provision of emergency care;
- vii. provide a system to assure continuing education for hospice medical staff as needed;
- viii. participate in the development of the POC prior to providing care, unless the POC has been established by an attending physician who is not also the medical director or physician designee;
- ix. participate in the review and update of the POC, unless the plan of care has been reviewed/updated by

the attending physician who is not also the medical director or physician designee. These reviews shall be documented;

- x. develop and coordinate policies and procedures for the provision of patient care;
- xi. attend IDT meetings;
- xii. document evidence of active participation in the hospice program (i.e. performance of above responsibilities and time spent upon performance of those responsibilities); and
- xiii. shall be readily available to the hospice staff.

c. Continuous Medical Education (CME). The medical director shall annually complete two hours of CME related to end of life care. Documentation of this CME shall be maintained in the medical director's personnel record.

2. An advanced practice registered nurse (APRN), legally authorized to practice advanced practice nursing in the state, shall not function as the medical director of the hospice but may be the licensed medical practitioner of individual hospice patients and meet the requirements of §8217.I.1.b.i-xii.

a. The APRN shall not be the referring practitioner and shall not be the signer of certification of terminal illness (CTI).

J. Social Worker

1. Qualifications. The social worker shall be an individual who holds a current, valid license as a social worker (LMSW) issued by the Louisiana State Board of Social Work Examiners (LSBSWE), has master's degree from a school of social work accredited by the Council on Social Work Education, and who meets the following:

- a. has at least one year of health care experience;
- b. has documented clinical experience appropriate to the counseling and casework needs of the terminally ill;
- c. shall be an employee of the hospice; and
- d. when the social worker is employed by one or more agencies, he/she shall inform all employers and cooperate and coordinate duties to assure the highest performance of quality when providing services to the patient.

2. Responsibilities. The social worker shall assist the licensed medical practitioner and other IDT members in understanding significant social and emotional factors related to the patient's health status and shall include, but not be limited to:

- a. assessment of the psychological, social and emotional factors having an impact on the patient's health status;
- b. assist in the formulation of the POC;
- c. provide services within the scope of practice as defined by state law and in accordance with the POC;

d. coordination with other IDT members and participate in IDT conferences;

e. prepare clinical and/or progress notes and incorporate them into the clinical record within one week of the visit;

f. participate in discharge planning, and in-service programs related to the needs of the patient;

g. acts as a consultant to other members of the IDT; and

h. when medical social services are discontinued, submit a written summary of services provided, including an assessment of the patient's current status, to be retained in the clinical record.

3. Continuing Education. The social worker shall annually obtain two hours of continuing education hours related to end of life care including but not limited to the following topics:

a. Medicare/Medicaid regulations;

b. psychosocial issues;

c. community resources/services;

d. death and dying;

e. family/patient dynamics;

f. ethics; and

g. advanced directives and LaPOST.

K. Occupational Therapist

1. Qualifications. An occupational therapist shall be licensed by the state of Louisiana and registered by the American Occupational Therapy Association.

2. Responsibilities. The occupational therapist shall assist the licensed medical practitioner in evaluating the patient's level of functioning by applying diagnostic and prognostic procedures including, but not limited to, the following:

a. provide occupational therapy in accordance with the licensed medical practitioner's orders and the POC;

b. guide the patient in his/her use of therapeutic, creative, and self-care activities for the purpose of improving function, in a manner consistent with accepted standards of practice;

c. observe, record, and report to the licensed medical practitioner and/or interdisciplinary team the patient's reaction to treatment and any changes in the patient's condition;

d. instruct and inform other health team personnel including, when appropriate, hospice aides/homemakers and family members in certain phases of occupational therapy in which they may work with the patient;

e. document each visit made to the patient and incorporate notes into the clinical record within one week of the visit;

f. participate in IDT conference as needed with hospice staff; and

g. prepare written discharge summary when applicable, with a copy retained in patient's clinical record and a copy forwarded to the attending licensed medical practitioner.

3. Supervision of an Occupational Therapy Assistant

a. The occupational therapist shall conduct the initial assessment and establish the goals and treatment plan before the licensed and certified occupational therapy assistant may treat the patients on site without the physical presence of the occupational therapist.

b. The occupational therapist and the occupational therapy assistant shall schedule joint visits at least once every two weeks or every four to six treatment sessions.

c. The occupational therapist shall review and countersign all progress notes written by the licensed and certified occupational therapy assistant.

d. In the occupational therapist/occupational therapy assistant relationship, the supervising occupational therapist retains overall personal responsibility to the patient, and accountability to the Louisiana Board of Medical Examiners for the patients' care.

e. The supervising occupational therapist is responsible for:

i. assessing the competency and experience of the occupational therapy assistant;

ii. establishing the type, degree and frequency of supervision required in the hospice care setting.

L. Occupational Therapy Assistant (OTA)

1. Qualifications. The occupational therapist assistant shall be licensed by the Louisiana Board of Medical Examiners to assist in the practice of occupational therapy under the supervision of a licensed registered occupational therapist and have at least two years' experience as a licensed OTA before starting their hospice caseload.

M. Physical Therapist (PT). The physical therapist, when provided, shall be available to perform in a manner consistent with accepted standards of practice.

1. Qualifications. The physical therapist shall be currently licensed by the Louisiana State Board of Physical Therapy Examiners.

2. Responsibilities. The physical therapist shall evaluate the patient's functional status and physical therapy needs in a manner consistent with standards of practice to include, but is not limited to, the following:

a. assist in the formation of the POC;

b. provide services within the scope of practice as defined by state law governing the practice of physical therapy, in accordance with the POC, and in coordination with the other members of the IDT;

c. observe, and report to the licensed medical practitioner and the IDT, the patient's reaction to treatment and any changes in the patient's condition;

d. instruct and inform participating members of the IDT, the patient, family/care givers, regarding the POC, functional limitations and progress toward goals;

e. prepare clinical and progress notes for each visit and incorporate them into the clinical record within one week of the visit;

f. when physical therapy services are discontinued, prepare written discharge summary, with a copy retained in the patient's clinical record and a copy forwarded to the attending licensed medical practitioner;

g. participate in IDT conference as needed with hospice staff.

3. Supervision of Physical Therapy Assistant (PTA)

a. The physical therapist shall be readily accessible by telecommunications.

b. The physical therapist shall evaluate and establish a written treatment plan on the patient prior to implementation of any treatment program.

c. The physical therapist shall treat and reassess the patient on at least every sixth visit, but not less than once per month.

d. The physical therapist shall conduct, once weekly, a face-to-face patient care conference with each PTA to review progress and modification of treatment programs for all patients.

e. The physical therapist shall assess the final treatment rendered to the patient at discharge and write a discharge summary.

N. Physical Therapy Assistant (PTA)

1. Qualifications. A physical therapy assistant shall be licensed by the Physical Therapy Board of Louisiana and supervised by a physical therapist.

2. Responsibilities. The physical therapy assistant shall:

a. provide therapy in accordance with the POC;

b. document each visit made to the patient and incorporate notes into the clinical record at least weekly; and

c. participates in IDT conference as needed with hospice staff.

O. Registered Nurse (RN). The hospice shall designate an RN to coordinate the implementation of the POC for each patient.

1. Qualifications. A licensed RN shall be currently licensed to practice in the state of Louisiana with no restrictions:

a. have at least two years of full-time experience as an RN. However, two years of full-time clinical experience in hospice care as an LPN may be substituted for the required two years of experience as an RN; and

EXCEPTION: The requirement in 1.a is waived for any RN that becomes employed by a hospice provider during a declared PHE which extends statewide and continues for more than 90 consecutive days. Any RN hired under this exception may continue to be employed by the same hospice provider after the PHE is over.

b. be an employee of the hospice. If the RN is employed by more than one agency, he/she must inform all employers and coordinate duties to assure quality service provision.

2. Responsibilities. The registered nurse shall identify the patient/family's physical, psychosocial, and environmental needs and reassess as needed but no less than every 14 days:

a. provide nursing services in accordance with the POC;

b. document problems, appropriate goals, interventions, and patient/family response to hospice care;

c. collaborate with the patient/family, attending licensed medical practitioner and other members of the IDT in providing patient and family care;

d. instruct patient/family in self-care techniques when appropriate;

e. supervise ancillary personnel and delegates responsibilities when required;

f. complete and submit accurate and relevant clinical notes regarding the patient's condition into the clinical record within one week of the visit;

g. if a home hospice/homemaker is assigned to a patient by the RN, in accordance with the POC, specific written instructions for patient care are to be prepared by the RN. All personal care services are to be outlined for the patient, in writing, by the RN in charge of that patient;

h. supervise and evaluate the hospice aide/homemaker's ability to perform assigned duties, to relate to the patient and to work effectively as a member of the health care team;

i. perform supervisory visits to the patient's residence at least every 14 days to assess relationships and determine whether goals are being met. A supervisory visit with the aide present shall be made at least annually. Documentation of the aide present supervisory visit shall be placed in the hospice aide's personnel record;

j. document supervision, to include the aide/homemaker-patient relationships, services provided and instructions and comments given as well as other requirements of the clinical note;

k. annual performance review for each aide/homemaker documented in the individual's personnel record; and

1. annually conduct an on-site LPN supervisory visit with the LPN present. Documentation of such visit shall be kept in the LPN's personnel record.

3. Continuing Education. The registered nurse shall annually obtain at least two hours of continuing education hours related to end of life care.

P. Speech Pathology Services

1. Qualifications. A speech pathologist shall:

a. be licensed by the state of Louisiana and certified by the American Speech and Hearing Association; or

b. completed the academic requirements and is in the process of accumulating the necessary supervised (as directed by the state certifying body) work experience required for certification. Evidence of this supervision will be retained in the non-certified speech pathologist's personnel folder.

2. Responsibilities. The speech pathologist shall assist the attending licensed medical practitioner in evaluation of the patient to determine the type of speech or language disorder and the appropriate corrective therapy in a manner consistent with standards of practice to include, but is not limited to, the following:

a. provide rehabilitative services for speech and language disorders;

b. observe, record and report to the attending licensed medical practitioner and the IDT the patient's reaction to treatment and any changes in the patient's condition;

c. instruct other health personnel and family members in methods of assisting the patient to improve and correct speech disabilities;

d. communicate with the registered nurse, director of nurses, and/or the IDT the need for a continuation of speech pathology services for the patient;

e. participate in IDT conferences;

f. document each visit made to the patient and incorporate notes into the clinical record within one week of the visit; and

g. prepare written discharge summary as indicated, with a copy retained in patient's clinical record and a copy forwarded to the attending licensed medical practitioner.

Q. Volunteers. Volunteers play a vital role in enhancing the quality of care delivered to the patient/family by encouraging community participation in the overall hospice program. Volunteers that provide patient care and support services according to their experience and training shall do so in compliance with agency policies, and under the supervision of a designated hospice employee.

1. Qualifications. A mature, non-judgmental, caring individual supportive of the hospice concept of care, willing to serve others, and appropriately oriented and trained. Volunteers who are qualified to provide professional services shall meet all standards associated with their specialty area.

2. Responsibilities. The volunteer shall:

a. provide assistance to the hospice program, and/or patient/family in accordance with designated assignments;

b. provide input into the plan of care and interdisciplinary team meetings, as appropriate;

c. document services provided as trained and instructed by the hospice agency;

d. maintain strict patient/family confidentiality; and

e. communicate any changes or observations to the assigned supervisor.

3. Training. The volunteers shall receive appropriate documented training which shall include at a minimum:

a. an introduction to hospice;

b. the role of the volunteer in hospice;

c. concepts of death and dying;

d. communication skills;

e. care and comfort measures;

f. diseases and medical conditions;

g. psychosocial and spiritual issues related to death and dying;

h. the concept of the hospice family;

i. stress management;

j. bereavement;

k. infection control;

l. safety;

m. confidentiality;

n. patient rights;

o. the role of the IDT; and

p. additional supplemental training for volunteers working in specialized programs (e.g. nursing facilities).

4. The hospice shall offer relevant in-service training on a quarterly basis and maintain documentation of such.

5. Pursuant to state law, requirements for minimum volunteer services shall be at least 5 percent of the total hours of service of the hospice agency.

R. Volunteer Coordinator. The hospice shall designate an employee of the agency who is skilled in organization and documentation as a volunteer coordinator.

1. Responsibilities. The volunteer coordinator shall be responsible for:

- a. overseeing the volunteer program;
- b. recruitment, retention, and education of volunteers;
- c. coordinating the services of volunteers with the patient and/or family; and
- d. attending IDT meetings.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR:15:482 (June 1989), amended LR 24:2262 (December 1998), LR 25:2409 (December 1999), LR 29:2801 (December 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 44:594 (March 2018), LR 47:1307 (September 2021).

Subchapter C. Patient Care Services

§8219. Patient Care Standard

A. Patient Certification. To be eligible for hospice care, an individual, or his/her representative, shall sign an election statement with a licensed hospice; the individual shall have a certification of terminal illness and shall have a plan of care (POC) which is established before services are provided.

B. Admission Criteria. The hospice shall have written policies to be followed in making decisions regarding acceptance of patients for care. Decisions are based upon medical, physical and psychosocial information provided by the patient's attending licensed medical practitioner, the patient/family and the interdisciplinary team. The admission criteria shall include:

1. the ability of the agency to provide core services on a 24-hour basis and provide for or arrange for non-core services on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions;

2. certification of terminal illness (CTI) signed by the attending licensed medical practitioner and the medical director of the agency;

NOTE: The CTI shall not be signed by an APRN

3. assessment of the patient/family needs and desires for hospice services;

4. informed consent signed by patient or representative who is authorized in accordance with state law to elect the hospice care, which will include the purpose and scope of hospice services; and

5. patient meets all other criteria required by any applicable payor sources.

C. Admission procedure. Patients are to be admitted only upon the order of the patient's attending physician.

1. An assessment visit shall be made by a registered nurse, who will assess the patient's needs with emphasis on pain and symptom control. This assessment shall occur within 48 hours of referral for admission, unless otherwise

ordered by physician or unless a request for delay is made by patient/family.

2. Documentation at admission will be retained in the clinical record and shall include:

- a. signed consent forms;
- b. signed patient's rights statement;
- c. clinical data including physician order for care;
- d. patient release of information;
- e. patient's signed designation of attending licensed medical practitioner;
- f. orientation of patient/caregiver, which includes:
 - i. advanced directives and LaPOST;
 - ii. agency services;
 - iii. patient's rights; and
 - iv. agency contact procedures; and

- g. for an individual who is terminally ill, certification of terminal illness signed by the medical director or the physician member of the IDT and the individual's attending physician.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2268 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:598 (March 2018).

§8221. Plan of Care (POC)

A. Prior to providing care, a written plan of care is developed for each patient/family by the attending physician, the medical director, physician designee or the APRN and the IDT. The care provided to an individual shall be in accordance with the POC.

1. The initial plan of care (IOPC) will be established on the same day as the assessment if the day of assessment is to be a covered day of hospice.

2. The IDT member who assesses the patient's needs shall meet or call at least one other IDT member before writing the IPOC. At least one of the persons involved in developing the IPOC shall be a registered nurse or physician. Within two days of the assessment, the other members of the IDT shall review the IPOC and provide their input. This input may be by telephone. The IPOC shall be signed by the attending licensed medical practitioner and an appropriate member of the IDT.

3. At a minimum the POC shall include the following:

- a. an assessment of the individual's needs and identification of services, including the management of discomfort and symptom relief;

- b. in detail, the scope and frequency of services needed to meet the patient's and family's needs;

c. identification of problems with realistic and achievable goals and objectives;

d. medical supplies and appliances including drugs and biologicals needed for the palliation and management of the terminal illness and related conditions;

e. patient/family understanding, agreement and involvement with the POC; and

f. recognition of the patient/family's physiological, social, religious and cultural variables and values.

4. The POC is incorporated into the individual clinical record.

5. The hospice shall designate a registered nurse to coordinate the implementation of the POC for each patient.

B. Review and Update of the Plan of Care. The plan of care is reviewed and updated at intervals specified in the POC, when the patient's health status changes, and a minimum of every 14 days for home care and every 7 days for general inpatient/continuous care, collaboratively with the IDT and the attending licensed medical practitioner.

NOTE: In the event that the day of the regularly scheduled IDT meeting falls on a holiday, 15 days is acceptable.

1. The hospice agency shall have policy and procedures for the following:

a. the attending licensed medical practitioner's participation in the development, revision, and approval of the POC is documented. This is evidenced by change in patient orders and documented communication between hospice staff and the attending licensed medical practitioner;

b. orders shall be signed and dated in a timely manner, not to exceed 14 days, unless the hospice has documentation that verifies attempts to get orders signed (in this situation up to 30 days will be allowed).

2. The agency shall have documentation that the patient's health status and POC is reviewed and the POC updated, even when the patient's health status does not change.

C. Coordination and Continuity of Care. The hospice shall adhere to the following additional principles and responsibilities:

1. an assessment of the patient/family needs and desire for hospice services and a hospice program's specific admission, transfer, and discharge criteria determine any changes in services;

2. nursing services, physician services, and drugs and biologicals are routinely available to hospice patients on a 24-hour basis, seven days a week;

3. all other covered services are available on a 24-hour basis to the extent necessary to meet the needs of individuals for care that is reasonable and necessary for the palliation and management of terminal illness and related conditions;

4. case-management is provided and an accurate and complete documented record of services and activities describing care of patient/family is maintained;

5. collaboration with other providers to ensure coordination of services;

6. maintenance of professional management responsibility and coordination of the patient/family care regardless of the setting;

7. maintenance of contracts/ agreements for the provision of services not directly provided by the hospice, including but not limited to:

a. radiation therapy;

b. infusion therapy;

c. inpatient care;

d. consulting physician;

8. provision or access to emergency medical care;

9. when home care is no longer possible, assistance to the patient in transferring to an appropriate setting where hospice care can be delivered;

10. when the patient is admitted to a setting where hospice care cannot be delivered, hospice adheres to standards, policies and procedures on transfer and discharge and facilitates the patient's transfer to another care provider;

11. maintenance of appropriately qualified IDT health care professionals and volunteers to meet patients need;

12. maintenance and documentation of a volunteer staff to provide administrative or direct patient care. The hospice shall document a continuing level of volunteer activity;

13. coordination of the IDT, as well as of volunteers, by a qualified health care professional, to assure continuous assessment, continuity of care and implementation of the POC;

14. supervision and professional consultation by qualified personnel, available to staff and volunteers during all hours of service;

15. hospice care provided in accordance with accepted professional standards and accepted code of ethics;

16. each member of the IDT accepts a fiduciary relationship with the patient/family, maintaining professional boundaries and an understanding that it is the responsibility of the IDT to maintain appropriate agency/patient/family relationships;

17. has a written agency policy to follow at the time of death of the patient; and

18. has written agency policies and procedures for emergency response based on an all hazards risk assessment, inclusive of training for employees, patients and their caregivers.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2268

(December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:599 (March 2018).

§8223. Pharmaceutical Services

A. Hospice provides for the pharmaceutical needs of the patient, consistent with the Board of Pharmacy regulations.

1. Agency shall institute procedures which protect the patient from medication errors.

2. Agency shall provide verbal and written instruction to patient and family as indicated.

3. Drugs and treatments are administered by agency staff only as ordered by the licensed medical practitioner.

B. Hospice ensures the appropriate monitoring and supervision of pharmaceutical services and has written policies and procedures governing prescribing, dispensing, administering, controlling, storing and disposing of all biologicals and drugs in compliance with applicable laws and regulations.

C. Hospice ensures timely pharmaceutical services on a 24 hour a day/seven day a week basis that include provision of drugs, biologicals and infusion services which are consistent with patient's individual drug profile.

D. Hospice provides the IDT and the patient/family with coordinated information and instructions about individual drug profiles.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2269 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:599 (March 2018).

§8225. Pathology and Laboratory Services

A. Hospice provides or has access to pathology and laboratory services which comply with CLIA guidelines and meet patient's needs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2269 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:599 (March 2018).

§8227. Radiology Services

A. Radiology services provided by hospice either directly; or under arrangements that shall comply with applicable federal and state laws, rules and regulations.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2269 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:599 (March 2018).

§8229. Discharge/Revocation/Transfer

A. Hospice provides adequate and appropriate patient/family information at discharge, revocation, or transfer.

B. Discharge. Patient shall be discharged only in the following circumstance:

1. change in terminal status;

2. patient relocates from the hospice's defined geographical service area;

3. if the safety of the patient or of the hospice staff is compromised. The hospice shall make every effort to resolve these problems satisfactorily before discharge. All efforts by the hospice to resolve the problem shall be documented in detail in the patient's clinical record; and

4. if the patient enters a non-contracted nursing facility or hospital and all options have been exhausted (a contract is not attainable or the patient chooses not to transfer to a facility with which the hospice has a contract, the hospice shall then discharge the patient. The hospice shall notify the payor source to document that all options have been pursued and that the hospice is not "dumping" the patient;

5. the hospice shall clearly document why the hospice found it necessary to discharge the patient.

C. Revocation. Occurs when the patient or representative makes a decision to discontinue receiving hospices services:

1. a recipient may revoke hospice care at any time. This is a right that belongs solely and exclusively to the patient or representative;

2. an effective date earlier than the actual date the revocation is made and signed cannot be designated;

3. if a patient or representative chooses to revoke from hospice care, the patient shall sign a statement that he or she is aware of the revocation and stating why revocation is chosen.

D. Non Compliance. When a patient is non-compliant, the hospice may counsel the patient/family on the option to revoke and any advantages or disadvantages of the decision that is made. A patient is considered non-compliant if:

1. the patient seeks or receives curative treatment for the illness; or

2. the patient seeks treatment related to the terminal illness in a facility that does not have a contract with the hospice;

3. the patient seeks treatment related to the terminal illness that is not in the POC, or is not pre-approved by the hospice.

E. Transfer. To change the designation of hospice programs, the individual must file with the hospice from which he/she has received care and with the newly designated hospice, a signed statement which includes the following information:

1. the name of the hospice from which the individual has received care;
2. the name of the hospice to which he/she plans to receive care;
3. the date of discharge from the first hospice and the date of admission to the second hospice; and
4. the reason for the transfer;
5. appropriate discharge plan/summary is to be written, and appropriate continuity of care is to be arranged.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2269 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:599 (March 2018).

§8231. Patient Rights and Responsibilities

A. The hospice shall insure that the patient has the right to:

1. be cared for by a team of professionals who provide high quality comprehensive hospice services as needed and appropriate for patient/family;
2. have a clear understanding of the availability of hospice services and the hospice team 24 hours a day, 7 days a week;
3. receive appropriate and compassionate care, regardless of diagnosis, race, age, gender, creed, disability, sexual orientation, place of residence, or the ability to pay for the services rendered;
4. be fully informed regarding patient status in order to participate in the POC. The hospice professional team will assist patient/family in identifying which services and treatments will help attain these goals;
5. be fully informed regarding the potential benefits and risks of all medical treatments or services suggested, and to accept or refuse those treatments and/or services as appropriate to patient/family personal wishes;
6. be treated with respect and dignity;
7. have patient/family trained in effective ways of caring for patient;
8. confidentiality with regard to provision of services and all patient records, including information concerning patient/family health status, as well as social, and/or financial circumstances. The patient information and/or records may be released only with patient/family's written consent, and/or as required by law;
9. voice grievances concerning patient care, treatment, and/or respect for person or privacy without being subject to discrimination or reprisal, and have any such complaints investigated by the hospice; and
10. be informed of any fees or charges in advance of services for which patient/family may be liable. Patient/family has the right to access any insurance or entitlement program for which patient may be eligible.

B. Informed Consent. An informed consent form that specifies the type of care and services that may be provided as hospice care during the course of the illness shall be obtained, either from the individual or representative.

C. The patient has the responsibility to the best of their ability to:

1. participate in developing the POC and update as his or her condition/needs change;
2. provide hospice with accurate and complete health information;
3. remain under a doctor's care while receiving hospice services; and
4. assist hospice staff in developing and maintaining a safe environment in which patient care can be provided.

D. The agency shall have written policies and procedures to address these concerns identified under §8231.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2270 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:600 (March 2018).

§8233. Clinical Records

A. In accordance with accepted principles of practice the hospice shall establish and maintain a clinical record (either hard copy or electronic) for every individual receiving care and services. The record shall be complete, promptly and accurately documented, legible, readily accessible and systematically organized to facilitate retrieval. The clinical record shall contain all pertinent past and current medical, nursing, social, and other therapeutic information, including the current POC under which services are being delivered.

B. Hospice records shall be maintained in a distinct location and not mingled with records of other types of health care related agencies.

C. Original clinical records shall be kept in a safe and confidential area which provides convenient access to clinicians.

D. The agency shall have policies addressing who is permitted access to the clinical records. No unauthorized person shall be permitted access to the clinical records.

E. All clinical records shall be safeguarded against loss, destruction and unauthorized use.

F. Records shall be maintained for six years from the date of discharge, unless there is an audit or litigation affecting the records. Records for individuals under the age of majority shall be kept in accordance with current state and federal law.

G. When applicable, the agency will obtain a signed "release of information" from the patient and/or the patient's family; a copy will be retained in the record.

H. The clinical record shall contain a comprehensive compilation of information including, but not limited to, the following:

1. initial and subsequent Plans of Care and initial assessment;
2. certifications of terminal illness;
3. written orders for admission and changes to the POC;
4. current clinical notes (at least the past 60 days);
5. plan of care;
6. signed consent, authorization and election forms;
7. pertinent medical history; and
8. identifying data, including name, address, date of birth, sex, agency case number; and next of kin.

I. Entries are made for all services provided and are signed by the staff providing the service.

J. Complete documentation of all services and events (including evaluations, treatments, progress notes, etc.) are recorded whether furnished directly by hospice staff or by arrangement.

K. The agency may produce, maintain and store records either in paper documentation form or in electronic form. Records stored in electronic form shall be password protected.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2270 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:600 (March 2018).

Subchapter D. Administration

§8235. Agency Operations

A. Premises (see definition of Hospice Premises).

1. Staff shall be able to distinguish and describe the scope and delineation of all activities being provided by the hospice.

2. Staff working areas are to be designed so that when planning for services, patient confidentiality is maintained.

3. The hospice shall have a distinct telephone number. If the telephone number is shared with other health care related agencies, the telephone operator(s) shall demonstrate knowledge and ability to distinguish and direct calls to the appropriate persons. If an answering service is used after normal hours, there shall be evidence of distinct hospice staff and the answering service should be able to direct calls to the appropriate persons for each service.

4. The hospice shall not share office space with a non-health care related entity. When office space is shared with another health care related entity the hospice agency shall operate separate and apart.

B. Hours of Operation

1. The hospice shall be required to have regular posted (in a prominent and easily accessible manner) business days and hours and be fully operational at least 8 hours a day, 5 days a week between 7 a.m. and 6 p.m. Hospice services are available 24 hours per day, 7 days a week, which include, at a minimum:

- a. professional registered nurse services;
- b. palliative medications;
- c. other services, equipment or supplies necessary to meet the patient's immediate needs.

2. Hospice provides on-call medical and nursing services to assess and meet changing patient/family needs, provide instruction and support, and conduct additional on-site assessment or treatment, 24 hours a day, 7 days per week.

a. The on-call RN shall triage calls and may delegate to another employee as appropriate.

C. Policies and Procedures:

1. shall be written, current, and annually reviewed by appropriate personnel;

2. shall contain policies and procedures specific to agency addressing personnel standards and qualifications, agency operations, patient care standards, problem and complaint resolution, purpose and goals of operation, the hospice's defined service area, as well as regulatory and compliance issues, inclusive of but not limited to, a full disclosure policy when employing and assigning to a patient, a state certified hospice attendant;

3. shall clarify the agency's prohibited use of social media. The policy shall ensure that all staff, either contracted or directly employed, receive training relative to the restrictive use of social media that includes, at a minimum, confidentiality of patient information, preservation of patient dignity and respect, protection of patient privacy and personal and property rights;

4. shall meet or exceed requirements of the minimum standards and all applicable federal, state, and local laws, including but not limited to criminal histories conducted by the Louisiana State Police, or its designee, on all non-licensed persons providing nursing care, health-related services, or supportive services to any patient; and

5. shall include a process for checking the direct service worker registry and the Louisiana certified nurse aide registry upon hiring an employee, and every six months thereafter, to ensure that non-licensed direct care staff do not have a finding placed against him/her of abuse, neglect, or misappropriation of funds of an individual. If there is such a finding on the DSW and/or CNA registry, the applicant shall not be employed nor does a current employee have continued employment with the hospice agency.

D. Operational Requirements

1. Hospice's responsibility to the community:

a. shall not accept orders to assess or admit from any source other than licensed physician or authorized physician representative (e.g. hospital discharge planner). Although the hospice may provide care to relatives of employees, the order to admit to the hospice shall be initiated by the primary attending physician;

b. shall use only factual information in advertising;

c. shall not participate in door to door solicitation;

d. shall not accept as a patient any person who is not terminally ill;

e. shall develop policy/procedure for patients with no or limited payor source;

f. shall have policy and procedures and a written plan for emergency operations in case of disaster including that at any time the hospice has an interruption in services or a change in the licensed location due to an emergency situation, the hospice shall notify the HSS no later than the next stated business day;

g. provide all services needed in a timely manner, at least within 24 hours, unless orders by the licensed medical practitioner indicate otherwise. However, admission timeframes shall be followed as indicated in the admission procedures subsection;

h. is prohibited from harassing or coercing a prospective patient or staff member to use a specific hospice or to change to another hospice;

i. shall have policy and procedures for post-mortem care in compliance with all applicable federal, state, and local laws;

j. may participate as community educators in community/health fairs; and

k. may provide free non-invasive diagnostic tests, such as blood pressure screening.

2. Hospice's responsibility to the patient shall include, but is not limited to, the following:

a. be in compliance with Minimum Standards and all applicable federal, state, and local laws at all times;

b. provide all Core services directly by the hospice agency and any non-core services required to meet the patient/family's needs;

c. act as the patient advocate in medical decisions affecting the patient;

d. protect the patient from unsafe skilled and unskilled practices;

e. protect the patient from being harassed, bribed, and/or any form of mistreatment by any employee or volunteer of the agency;

f. provide patient information on the patient's rights and responsibilities;

g. provide information on advanced directives and LaPost in compliance with all applicable federal, state, and local laws;

h. protect and assure that patient's rights are not violated;

i. focus on enabling the patient remaining in the familiar surroundings of his/her place of residence as long as possible and appropriate;

j. encourage the patient/family to participate in developing the POC and provision of hospice services;

k. with the permission of the patient, include in the POC specific goals for involving the patient/family;

l. make appropriate referrals for family members outside the hospice's service area for bereavement follow-up;

m. whenever a hospice program manages and/or delivers care in a facility, ensure that an appropriate standard of care is provided to the patient in the facility, regardless of whether or not hospice is responsible for the direct provision of those services;

n. ensure that any facility where hospice care is provided meets appropriate licensing requirements and any payor source requirements when applicable;

o. ensure that any facility in which hospice care is provided have the following:

i. areas that are designed and equipped for the comfort and privacy of each patient and family member;

ii. physical space for private patient/family visiting;

iii. accommodations for family members to remain with the patient throughout the night;

iv. accommodations for family privacy after a patient's death;

v. decor which is homelike in design and function; and

vi. patients shall be permitted to receive visitors at any hour, including small children.

3. Responsibility of the hospice to the staff shall include, but is not limited to, the following:

a. provide safe environment whenever the hospice knows or has reason to know that environment might be dangerous;

b. have safety and emergency preparedness programs that conform with federal, state, and local requirements and that include:

i. a plan for reporting, monitoring, and follow-up on all accidents, injuries, and safety hazards;

ii. documentation of all reports, monitoring activity, and follow-up actions, education for patient/family, care givers, employees and volunteers on the safe use of medical equipment;

iii. evidence that equipment maintenance and safety requirements have been met;

iv. policies and procedures for storing, accessing, and distributing controlled drugs, supplies and equipment;

v. a safe and sanitary system for identifying, handling, and disposing of hazardous wastes; and

vi. a policy regarding use of smoking materials in all care settings;

c. have policies which encourage realistic performance expectations;

d. maintain insurance and worker's compensation at all times;

e. provide adequate time on schedule for required travel;

f. meet or exceed Wage and Hour Board requirements;

g. provide adequate information, in-service training, supplies, and other support for all employees to perform to the best of their ability;

h. provide in-service training to promote effective, quality hospice care; and

i. have training on the prohibited use of social media.

4. Responsibility of the hospice prior to employment of a state certified hospice attendant includes, but is not limited to, the following:

a. the hospice provider shall notify HSS of the intent to hire a state certified hospice attendant; and

b. the hospice provider shall have documentation of certification of the state certified hospice attendant meeting the requirements of R.S. 40:2192.

5. Responsibility of the hospice subsequent to employment of a state certified hospice attendant includes, but is not limited to, the following:

a. the hospice provider shall disclose to its employees, patients, and patients' immediate family members that the state certified hospice attendant has successfully completed all state certification training and registry requirements for employment, including successful completion and release from a sentence served at a state prison;

b. upon change in status of employment of the state certified hospice attendant, the hospice provider shall notify HSS;

c. the hospice provider shall ensure that the state certified hospice attendant receives required continuing education or training requirements to maintain state certification in good standing continuously during employment by the hospice provider; and

d. the hospice provider shall ensure that the state certified hospice attendant has continuing education

equivalent to a hospice aide/CNA, inclusive of the following:

i. a minimum of 12 hours of job-related in-service training annually, specific to their job responsibilities within the previous 12 months;

ii. at least two of the required 12 hours of annual job-related in-service training shall focus on end of life care; and

iii. ensure six of the 12 hours of required annual job-related in-service training shall be provided every six months.

6. Access by the hospice agency to the state certified hospice attendant registry established by the department pursuant to R.S. 40:2192 shall be limited to an inquiry for a specific state certified hospice attendant.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and R.S. 40:2181-2192.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2271 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:600 (March 2018), LR 46:344 (March 2020).

§8237. Contract Services

A. When the hospice provides services on a contractual basis to a patient the hospice is responsible for all actions of the contract personnel.

B. The hospice shall not at any time use contract employees as administrator/alternate or for the provision of core services, except that physician or physician designee services may be provided through contract.

C. Whenever services are provided by an organization/individual other than the hospice, a written agreement will delineate services available and procedures for accessing those services.

D. Whenever services are provided by an outside agency or individual, a legally binding written agreement shall be effected. The legally binding written agreement shall include at least the following items:

1. identification of the services to be provided;

2. a stipulation that services may be provided only with the express authorization of the hospice;

3. the manner in which the contracted services are coordinated, supervised, and evaluated by the hospice;

4. the delineation of the role(s) of the hospice and the contractor in the admission process, patient/family assessment, and the IDT conferences;

5. requirements for documenting that services are furnished in accordance with the agreement;

6. the qualifications of the personnel providing the services;

7. assurance that the personnel contracted complete the clinical record in the same timely manner as required by the staff personnel of the hospice;

8. payment fees and terms; and

9. statement that the hospice retains responsibility for appropriate hospice care training of the personnel who provide care under the agreement.

E. The hospice shall document review of its contracts on an annual basis.

F. The hospice is to coordinate services with contract personnel to assure continuity of patient care.

G. Hospice maintains professional management responsibilities for those services and ensures that they are furnished in a safe and effective manner by qualified persons and in accordance with the patient's POC.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2272 (December 1998), LR 29:2801 (December 2003), amended by the Department of Health, Bureau of Health Services Financing, LR 44:601 (March 2018).

§8239. Quality Assurance/Performance Improvement

A. Agency shall have an on-going, comprehensive, integrated, self-assessment quality improvement process which provides assurance that patient care, including inpatient care, home care, and care provided by arrangement, is provided at all times in compliance with accepted standards of professional practice.

B. The hospice shall have written plans, policies and procedures addressing quality assurance and performance improvement.

C. Hospice shall monitor and evaluate its resource allocation regularly to identify and resolve problems with the utilization of its services, facilities and personnel.

D. Hospice shall follow a written plan for continually assessing and improving all aspects of operations which include:

1. goals and objectives;
2. the identity of the person responsible for the program;
3. a system to ensure systematic, objective regular reports are prepared and distributed to appropriate areas;
4. the method for evaluating the quality and the appropriateness of care;
5. a method for resolving identified problems; and
6. application to improving the quality of patient care.

E. The plan is reviewed at least annually and revised as appropriate.

F. The governing body and administration shall strive to create a work environment where problems can be openly addressed and service improvement ideas encouraged.

G. Quality assessment and improvement activities are based on the systematic collection, review, and evaluation of data which, at a minimum, includes:

1. services provided by professional and volunteer staff;
2. outcome audits of patient charts;
3. reports from staff, volunteers and patients about services;
4. concerns or suggestions for improvement in services;
5. organizational review of the hospice program;
6. patient/family evaluations of care; and
7. high-risk, high-volume and problem-prone activities.

H. When problems are identified in the provision of hospice care, there shall be evidence of corrective actions, including ongoing monitoring, revisions of policies and procedures, educational intervention and changes in the provision of services.

I. The effectiveness of actions taken to improve services or correct identified problems is evaluated.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2273 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:601 (March 2018).

§8241. Branch Offices

A. No branch office may be opened without written approval from LDH.

B. No branch office may be opened unless the parent office has had full licensure for at least the immediately preceding 12 months and has a current census of at least 10 active patients.

C. Each branch shall serve the same or part of the geographic area approved for the parent.

D. Each branch office shall have a registered nurse immediately available to be on site, or on site in the branch office at all times during stated operating hours.

E. All services provided by the parent agency shall be available in the branch.

F. The branch site shall retain all clinical records for its patients. Duplicate records need not be maintained at the parent agency, but shall be made available to federal/state surveyors during any review upon request.

G. Original personnel files are to be kept at the parent agency, but shall be made available to federal/state surveyors during any review upon request.

H. A statement of personnel policies is maintained in each branch for staff usage.

I. Approval for branch offices will be issued, in writing, by LDH for one year and will be renewed at time of annual renewal if the branch office:

1. is operational and providing hospice services;
2. serves only patients who are geographically nearer to the branch than to the parent office;
3. offers exact same services as the parent agency; and
4. if the parent office meets requirements for full licensure.

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HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2273 (December 1998), LR 25:2409 (December 1999), amended by the Department of Health, Bureau of Health Services Financing, LR 44:602 (March 2018).

§8243. Cessation of Business

A. Except as provided in §8245 and §8246 of these licensing regulations, a license shall be immediately null and void if a hospice ceases to operate.

B. A cessation of business is deemed to be effective the date on which the hospice stopped offering or providing services to the community.

C. Upon the cessation of business, the hospice shall immediately return the original license to the department.

D. Cessation of business is deemed to be a voluntary action on the part of the hospice. The hospice does not have a right to appeal a cessation of business.

E. Prior to the effective date of the closure or cessation of business, the hospice shall:

1. give 30 days' advance written notice to:
 - a. the HSS;
 - b. each patient's attending licensed medical practitioner; and
 - c. each patient or patient's legal representative, if applicable; and
2. provide for an orderly discharge and transition of all of the patients in the hospice.

F. In addition to the advance notice of voluntary closure, the hospice shall submit a written plan for the disposition of all patient medical records for approval by the department. The plan shall include:

1. the effective date of the voluntary closure;

2. provisions that comply with federal and state laws on storage, maintenance, access, and confidentiality of the closed hospice's patients' medical records;

3. an appointed custodian(s) who shall provide the following:

- a. access to records and copies of records to the patient or authorized representative, upon presentation of proper authorization(s); and
- b. physical and environmental security that protects the records against fire, water, intrusion, unauthorized access, loss and destruction; and

4. public notice regarding access to records, in the newspaper with the largest circulation in close proximity to the closing hospice, at least 15 days prior to the effective date of closure.

G. If a hospice fails to follow these procedures, the owners, managers, officers, directors, and administrators may be prohibited from opening, managing, directing, operating, or owning a hospice for a period of two years.

H. Once the hospice has ceased doing business, the hospice shall not provide services until the hospice has obtained facility need review approval and applied for initial licensure in accordance with requirements of this Chapter.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 15:482 (June 1989), amended LR 24:2274 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:602 (March 2018).

§8245. Inactivation of Licensure due to a Declared Disaster or Emergency

A. A hospice agency licensed in a parish which is the subject of an executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766 may seek to inactivate its license for a period not to exceed one year, provided that the following conditions are met:

1. the licensed agency shall submit written notification to the Health Standards Section within 60 days of the date of the executive order or proclamation of emergency or disaster that:

a. the hospice agency has experienced an interruption in the provisions of services as a result of events that are the subject of such executive order or proclamation of emergency or disaster issued in accordance with R.S. 29:724 or R.S. 29:766;

b. the hospice agency intends to resume operation as a hospice in the same service area;

c. includes an attestation that the emergency or disaster is the sole causal factor in the interruption of the provision of services;

d. includes an attestation that all patients have been properly discharged or transferred to another agency or facility; and

e. provides a list of patients and where that patient is discharged or transferred to;

2. the agency resumes operating as a hospice in the same service area within one year of the issuance of an executive order or proclamation of emergency or disaster in accordance with R.S. 29:724 et seq., or R.S. 29:766 et seq.;

3. the hospice continues to pay all fees and cost due and owed to the department including, but not limited to, annual licensing fees and outstanding civil monetary penalties; and

4. the hospice continues to submit required documentation and information to the department.

B. Upon receiving a completed written request to inactivate a hospice license, the department shall issue a notice of inactivation of license to the hospice.

C. Upon completion of repairs, renovations, rebuilding or replacement, a hospice agency which has received a notice of inactivation of its license from the department shall be allowed to reinstate its license upon the following conditions being met.

1. The hospice shall submit a written license reinstatement request to the licensing agency of the department 60 days prior to the anticipated date of reopening.

a. The license reinstatement request shall inform the department of the anticipated date of opening, and shall request scheduling of a licensing survey.

b. The license reinstatement request shall include a completed licensing application with appropriate licensing fees.

2. The agency resumes operating as a hospice in the same service area within one year.

D. Upon receiving a completed written request to reinstate a hospice license, the department shall conduct a licensing survey. If the hospice meets the requirements for licensure and the requirements under this Section, the department shall issue a notice of reinstatement of the hospice license.

1. The licensed capacity of the reinstated license shall not exceed the licensed capacity of the hospice agency at the time of the request to inactivate the license.

E. No change of ownership of the hospice agency shall occur until such agency has completed repairs, renovations, rebuilding or replacement construction, and has resumed operations as a hospice agency.

F. The provisions of this Section shall not apply to a hospice agency which has voluntarily surrendered its license and ceased operation.

G. Failure to comply with any of the provisions of this Section shall be deemed a voluntary surrender of the hospice license and any applicable facility need review approval for licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2274 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:602 (March 2018).

§8246. Inactivation of Licensure due to a Non-Declared Disaster or Emergency

A. A hospice in an area or areas which have been affected by a non-declared emergency or disaster may seek to inactivate its license, provided that the following conditions are met:

1. the hospice shall submit written notification to the Health Standards Section within 30 days of the date of the non-declared emergency or disaster stating that:

a. the hospice has experienced an interruption in the provisions of services as a result of events that are due to a non-declared emergency or disaster;

b. the hospice intends to resume operation as a hospice agency in the same service area;

c. the hospice attests that the emergency or disaster is the sole causal factor in the interruption of the provision of services; and

d. the hospice's initial request to inactivate does not exceed one year for the completion of repairs, renovations, rebuilding or replacement of the facility;

NOTE: Pursuant to these provisions, an extension of the 30 day deadline for initiation of request may be granted at the discretion of the department.

2. the hospice continues to pay all fees and costs due and owed to the department including, but not limited to, annual licensing fees and outstanding civil monetary penalties and/or civil fines; and

3. the hospice continues to submit required documentation and information to the department, including but not limited to cost reports.

B. Upon receiving a completed written request to temporarily inactivate a hospice license, the department shall issue a notice of inactivation of license to the hospice.

C. Upon receipt of the department's approval of request to inactivate the agency's license, the hospice shall have 90 days to submit plans for the repairs, renovations, rebuilding or replacement of the facility, if applicable, to the Office of the State Fire Marshal (OSFM) and the Office of Public Health (OPH) as required.

D. The hospice shall resume operating as a hospice in the same service area within one year of the approval of renovation/construction plans by OSFM and OPH as required.

EXCEPTION: If the hospice requires an extension of this timeframe due to circumstances beyond the agency's control, the department will consider an extended time period to complete construction or repairs. Such written request for extension shall show the agency's active efforts to complete construction or repairs and the reasons for request for extension of the agency's inactive license. Any approval for extension is at the sole discretion of the department.

E. Upon completion of repairs, renovations, rebuilding or replacement of the facility, a hospice which has received a notice of inactivation of its license from the department shall be allowed to reinstate its license upon the following conditions being met:

1. the hospice shall submit a written license reinstatement request to the licensing agency of the department;

2. the license reinstatement request shall inform the department of the anticipated date of opening and shall request scheduling of a licensing or physical environment survey, where applicable; and

3. the license reinstatement request shall include a completed licensing application with appropriate licensing fees.

F. Upon receiving a completed written request to reinstate a hospice license, the department may conduct a licensing or physical environment survey. The department may issue a notice of reinstatement if the agency has met the requirements for licensure including the requirements of this Subsection.

G. No change of ownership of the hospice shall occur until such hospice has completed repairs, renovations, rebuilding or replacement construction and has resumed operations as a hospice facility.

H. The provisions of this Subsection shall not apply to a hospice which has voluntarily surrendered its license and ceased operation.

I. Failure to comply with any of the provisions of this Subsection shall be deemed a voluntary surrender of the hospice license and any applicable facility need review approval for licensure.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 44:603 (March 2018).

Subchapter E. Hospice Inpatient Facility

§8247. Requirements for Licensure of Inpatient Hospice

A. Hospice inpatient services may be provided directly by the hospice or through arrangements made by the hospice. An agency is prohibited from providing hospice inpatient services only. A hospice that elects to provide hospice inpatient services directly is required to be licensed as a hospice agency and sublicensed as a hospice inpatient facility. Separate applications and fees are required. The

application process to establish a hospice inpatient facility may be completed simultaneously with an application to provide hospice services.

B. An application packet shall be obtained from LDH.

1. A completed application packet for a hospice inpatient facility shall be submitted to and approved by LDH prior to an agency providing hospice services.

2. The application submitted shall include the current licensing fee plus any bed fees. All fees shall be in the form of a company check, certified check or money order made payable to LDH. All fees submitted are non-refundable. All state-owned hospice facilities are exempt from fees.

3. The license shall be conspicuously displayed in the hospice inpatient facility.

4. Each initial applicant or an existing hospice inpatient facility requesting a change of address shall have approval from the following offices prior to an on-site survey by this department.

a. Office of Public Health—Local Health Unit. All hospice inpatient facilities shall comply with the rules, LAC Title 51, *Public Health—Sanitary Code* and enforcement policies as promulgated by OPH. It shall be the primary responsibility of OPH to determine if applicants are complying with those requirements. No initial license shall be issued without the applicant furnishing a certificate from OPH that such an applicant is complying with their provisions. A provisional license may be issued to the applicant if OPH issues the applicant a conditional certificate.

b. Office of the State Fire Marshal. All hospice inpatient facilities shall comply with the rules, established fire protection standards and enforcement policies as promulgated by OSFM. It shall be the primary responsibility of OSFM to determine if applicants are complying with those requirements. No license shall be issued or renewed without the applicant furnishing a certificate from OSFM that such applicant is complying with their provisions. A provisional license may be issued to the applicant if OSFM issues the applicant a conditional certificate.

C. New constructions shall be reviewed by OSFM for compliance with the applicable hospice licensing rules.

1. All new construction, other than minor alterations for a hospice inpatient facility, shall be done in accordance with the specific requirements of OSFM and OPH regulations covering new construction, including submission of preliminary plans and the final work drawings and specifications shall also be submitted prior to any change in facility type.

2. No new hospice inpatient facility shall be constructed, nor shall major alterations be made to existing hospice inpatient facilities, or change in facility type be made without the prior written approval of, and unless in accordance with plans and specifications approved in advance by the Department of Health and the Office of State Fire Marshal. The review and approval of plans and

specifications shall be made in accordance with the requirements of OSFM to include:

a. copies of the approval letters of the architectural and the licensing facility plans from OSFM and any other office/entity designated by the department to review and approve the facility's architectural and licensing plan review;

b. a copy of the on-site inspection report with approval for occupancy by OSFM, if applicable; and

c. a copy of the on-site health inspection report with approval for occupancy from OPH. Before any new hospice inpatient facility is licensed or before any alteration or expansion of a licensed hospice inpatient facility can be approved, the applicant shall furnish one complete set of plans and specifications to OSFM, with fees and other information as required. Plans and specifications for new construction other than minor alterations shall be prepared by or under the direction of a licensed architect and/or a qualified licensed engineer.

3. Notice of satisfactory review from OPH and OSFM for *Life Safety Code* (LSC) approval and licensing plan review constitutes compliance with this requirement if construction begins within 180 days of the date of such notice. This approval shall in no way permit and/or authorize any omission or deviation from the requirements of any restrictions, laws, regulations, ordinances, codes, or rules of any responsible agency.

D. An agency seeking to renew its license shall:

1. request a renewal application packet from LDH if one is not received at least 45 days prior to the license expiration date;

2. submit a renewal application packet annually accompanied by the current licensing fee plus any applicable bed fees.

E. An inpatient hospice facility shall maintain proof of compliance with all applicable local codes and ordinances governing health, fire, safety, and zoning regulations.

F. An agency shall notify LDH, in writing, prior to a change in name of the agency, address change, or a change in the number of beds.

1. A fee shall be submitted for a replacement license when a change occurs such as name change, address change, or a bed change.

2. The new facility location shall meet the same licensing requirements as those required for an initial survey including approval of building plans by OSFM and OPH.

G. A hospice that provides inpatient hospice services directly is required to provide or make arrangements for all hospice services on both an outpatient and an inpatient level including routine home care, continuous home care, respite care, and general inpatient care.

H. Hospice inpatient facilities and any facility that provides hospice services shall be maintained in a manner

which provides for maintaining personal hygiene of the patients and implementation of infection control procedures.

I. Equipment and furnishings in an inpatient facility shall provide for the health care needs of the patient while providing a home-like atmosphere.

J. Services provided in the inpatient facility are consistent with the plan of care prepared for that patient and are consistent with services provided by the hospice program in other settings.

K. The hospice provider shall ensure that each patient residing in an inpatient facility has an identified hospice staff member who will serve as that patient's principle advocate and contact person.

L. The hospice inpatient facility shall ensure the following:

1. the facility meets appropriate licensing, regulatory, and certification requirements;

2. the facility has an acceptable, written all hazards risk assessment and emergency preparedness plan. The plan shall include:

a. the frequency/schedule for periodically rehearsing the plan with the staff;

b. the assignment of personnel for specific responsibilities;

c. the procedures for prompt identification and transfer of patients and records to an appropriate facility;

i. in the event of an evacuation, the facility shall have a method to release patient information consistent with the HIPAA Privacy Rule;

d. fire and/or other emergency drills, in accordance with the LSC;

e. procedures covering persons in the facility and in the community in cases of all hazards (i.e., hurricanes, tornadoes, floods); and

f. arrangements with community resources in the event of a disaster;

3. the facility shall design and equip areas for the comfort and privacy of each patient and family members. The facility shall have the following:

a. physical space for private patient/family visiting;

b. accommodations for family members to remain with the patient throughout the night;

c. accommodations for family privacy after a patient's death;

d. decor which is homelike in design and function; and

e. patients shall be permitted to receive visitors at any hour, including small children;

4. patient rooms are designed and equipped for adequate nursing care and the comfort and privacy of patients. Each patient's room shall:

- a. be equipped with toilet and bathing facilities;
- b. be equipped with a lavatory in each patient's toilet room or in each bedroom;
- c. be at or above grade level;
- d. contain room decor that is homelike and non-institutional in design and function. Room furnishings for each patient shall include a bed with side rails, a bedside stand, an over-the-bed table, an individual reading light easily accessible to each patient and a comfortable chair. The patient shall be permitted to bring personal items of furniture or furnishings into their rooms unless medically inappropriate;
- e. have closet space that provides security and privacy for clothing and personal belongings;
- f. contain no more than 4 beds;
- g. measure at least 100 square feet for a single patient room or 80 square feet for each patient for a multi patient room; and
- h. be equipped with a device for calling the staff member on duty. A call bell or other communication mechanism shall be placed within easy reach of the patient and shall be functioning properly. A call bell shall be provided in each patient toilet, bath, and shower room;

5. the hospice inpatient facility shall:

- a. provide an adequate supply of hot water at all times for patient use;
- b. have plumbing fixtures with control valves that automatically regulate the temperature of the hot water used by patients; and
- c. designate a staff member responsible for monitoring and logging water temperatures at least monthly. This person is responsible for reporting any problems to the administrator;

6. the hospice inpatient facility shall have available at all times a quantity of linen essential for proper care and comfort of patients. Linens are handled, stored, processed, and transported in such a manner as to prevent the spread of infection. The facility shall have a clean linen storage area;

- a. the linen supply shall be adequate to accommodate the number of beds and the number of incontinent patients on a daily basis, including week-ends and holidays;
- b. soiled linen and clothing shall be collected and enclosed in suitable bags or containers in well ventilated areas, separate from clean linen and not permitted to accumulate in the facility;
- c. the hospice inpatient facility shall have policies and procedures that address:

- i. frequency of linen changes;
- ii. storage of clean linen; and
- iii. storage of soiled linen;

7. the hospice inpatient facility shall make provisions for isolating patients with infectious diseases. The hospice should institute the most current recommendations of The Centers for Disease Control and Prevention (CDC) relative to the specific infection(s) and communicable disease(s). The hospice provisions for isolating patients with infectious diseases shall include:

- a. definition of nosocomial infections and communicable diseases;
- b. measures for assessing and identifying patients and health care workers at risk for infections and communicable diseases;
- c. measures for prevention of infections, especially those associated with immunosuppressed patients and other factors which compromise a patient's resistance to infection;
- d. measures for prevention of communicable disease outbreaks, especially tuberculosis;
- e. provision of a safe environment consistent with the current CDC recommendations for the identified infection and/or communicable disease;
- f. isolation procedures and requirements for infected or immunosuppressed patients;
- g. use and techniques for universal precautions;
- h. methods for monitoring and evaluating practice of asepsis;
- i. care of contaminated laundry, i.e., clearly marked bags and separate handling procedures;
- j. care of dishes and utensils, i.e., clearly marked and handled separately;
- k. use of any necessary gowns, gloves or masks posted and observed by staff, visitors, and anyone else in contact with the patient; and
- l. techniques for hand washing, respiratory protection, asepsis sterilization, disinfection, needle disposal, solid waste disposal, as well as any other means for limiting the spread of contagion;
- m. orientation of all new hospice personnel to infections, to communicable diseases and to the infection control program; and
- n. employee health policies regarding infectious diseases, and when infected or ill employees shall not render direct patient care;

8. the hospice inpatient facility should isolate infected patients only to the degree needed to isolate the infecting organism. The method should be the least restrictive possible while maintaining the integrity of the process and the dignity of the patient;

9. the hospice inpatient facility shall provide the following:

- a. storage for administrative supplies;
- b. hand washing facilities located convenient to each nurses' station and medication distribution station;
- c. charting facilities for staff at each nurses' station;
- d. a "clean" workroom which contains a work counter, sink, storage facilities and covered waste receptacles;
- e. a "soiled" workroom for receiving and cleanup of equipment;
- f. parking for stretchers and wheelchairs in an area out of the path of normal traffic and of adequate size for the facility;
- g. a janitor's closet which contains a floor receptor with mop hooks over the sink and storage space for housekeeping equipment and supplies;
- h. a multi-purpose lounge or lounges shall be provided suitable and furnished for: reception, recreation, dining, visitation, group social activities, and worship. Such lounge or lounges shall be located convenient to the patient rooms designed to be served;
- i. a conference and consultation room shall be provided which is suitable and furnished for family privacy, including conjugal visit rooms, clergy visitations, counseling, and viewing of a deceased patient's body during bereavement. The conference and consultation room shall be located convenient to the patient rooms it is designed to serve;
- j. public telephone and restrooms shall be provided.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2274 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:604 (March 2018).

§8253. Nursing Services

A. There shall be an organized nursing service that provides 24-hour nursing services. The nursing services shall be under the direction of the director of nursing and in accordance with the requirements of §8217.E.1-2.e.ix.

B. The inpatient facility shall have staff on the premises on a 24 hour a day, 7 day a week basis when there are patients in the facility. The services provided shall be in accordance with the patient's plan of care. Each shift shall include two direct patient care staff, one of which shall be a registered nurse who provides direct patient care. The nurse to patient ratio shall be at least one nurse to every eight patients. In addition there shall be sufficient number of direct patient care staff on duty to meet the patient care needs. When there are no patients in the hospice inpatient facility, the hospice shall have a registered nurse on-call to be immediately available to the hospice inpatient facility.

C. Written nursing policies and procedures shall define and describe the patient care provided. There shall be a written procedure to ensure that all licensed nurses providing care in the inpatient hospice facility have a valid and current license to practice prior to providing any care.

D. Nursing services are either furnished and/or supervised by a registered nurse and all nursing services shall be evaluated by a registered nurse.

E. A registered nurse shall assign the nursing service staff for each patient in the inpatient hospice facility. The facility shall provide 24-hour nursing services which are sufficient to meet the total nursing needs of the patient and which are in accordance with the patient's plan of care. Staffing shall be planned so that each patient receives treatments, medication, and diet as prescribed, and is kept clean, well-groomed, and protected from accident, injury, and infection. Nursing services staff shall be assigned clinical and/or management responsibilities in accordance with education, experience and the current Louisiana Nurse Practice Act.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing LR 15:482 (June 1989), amended LR 24:2277 (December 1998), amended by the Department of Health, Bureau of Health Services Financing, LR 44:605 (March 2018).

§8255. Nutritional Services

A. Nutritional services shall be under the supervision of a registered dietitian, licensed to practice in Louisiana, who is employed either full-time, part-time or on a consulting basis. If the registered dietitian is not full-time, there shall be a full-time dietary manager who is responsible for the daily management of dietary services.

1. The registered dietitian shall be responsible for assuring that quality nutritional care is provided to patients by providing and supervising the nutritional aspects of patient care. The registered dietitian is also responsible for:

- a. recording the nutritional status of the patient;
- b. plan menus for those patients who require medically prescribed special diets; and
- c. supervise the preparation and serving of meals to ensure that the patient accepts the special diet.

2. The hospice inpatient facility shall have a dietary manager who is responsible for:

- a. planning menus that meet the nutritional needs of each patient, following the orders of the patient's licensed medical practitioner and, to the extent medically possible, the recommended dietary allowances of the Food and Nutrition Board of the National Academy of Sciences. There shall be a current therapeutic diet manual approved by the dietitian and medical staff, and readily available to all medical, nursing, and food service personnel, which shall be the guide used for ordering and serving diets.

b. supervising the meal preparation and service to ensure that the menu plan is followed.

3. A dietary manager shall meet one of the following:

a. a graduate of a dietetic technician or dietetic assistant training program by correspondence or classroom, approved by the American Dietetic Association;

b. a graduate of a State approved course that provides 90 or more hours of classroom instruction in food service supervision and has experience as a supervisor in a health care institution with consultation from a dietitian; or

c. has training and experience in food service supervision and management in the military or other service equivalent in content to a dietetic technician or dietetic assistant training program by correspondence or classroom, approved by the American Dietetic Association.

4. The hospice shall employ sufficient support personnel to meet the needs of the patients in the hospice inpatient facility.

5. The hospice shall have policies and procedures to ensure support personnel are competent to perform their respective duties within the dietary services department.

6. The hospice inpatient facility shall:

a. serve at least three meals or their equivalent each day at regular times, with not more than 14 hours between a substantial evening meal and breakfast;

b. include adequate nutritional services to meet the patient's dietary needs and food preferences, including the availability of frequent, small, or mechanically-altered meals 24 hours a day;

c. be designed and equipped to procure, store, prepare, distribute, and serve all food under sanitary conditions; and

d. provide a nourishment station which contains equipment to be used between scheduled meals such as a warming device, refrigerator, storage cabinets and counter space. There shall be provisions made for the use of small appliances and storage. This area shall be available for use by the patient, the patient's family, volunteers, guests and staff.

B. Sanitary Conditions

1. Food shall be in sound condition, free from spoilage, filth, or other contamination and shall be safe for human consumption.

a. All food shall be procured from sources that comply with all laws and regulations related to food and food labeling.

b. The use of food in sealed containers that was not prepared in a food processing establishment is prohibited.

c. All food shall be stored, prepared, distributed and served under sanitary conditions to prevent food borne illness. This includes keeping all readily perishable food and drink at or below 40 degrees Fahrenheit, except when being

prepared and served. Refrigerator temperatures shall be maintained at 40 degrees Fahrenheit or below; freezers at 0 degrees Fahrenheit or below.

d. Hot foods shall leave the kitchen or steam table at or above 140 degrees Fahrenheit. In-room delivery temperatures shall be maintained at 120 degrees Fahrenheit, or above for hot foods and 50 degrees Fahrenheit or below for cold items. Food shall be covered during transportation and in a manner that protects it from contamination while maintaining required temperatures.

e. All equipment and utensils used in the preparation and serving of food shall be properly cleansed, sanitized and stored. This includes maintaining a water temperature in dish washing machines at 140 degrees Fahrenheit during the wash cycle (or according to the manufacturer's specifications or instructions) and 180 degrees Fahrenheit for the final rinse. Low temperature machines shall maintain a water temperature of 120 degrees Fahrenheit with 50 ppm (parts per million) of hypochlorite (household bleach) on dish surfaces. For manual washing in a 3-compartment sink, a wash water temperature of 75 degrees Fahrenheit with 50 ppm of hypochlorite or equivalent, or 12.5 ppm of iodine; or a hot water immersion at 170 degrees Fahrenheit for at least 30 seconds shall be maintained. An approved lavatory shall be convenient and equipped with hot and cold water tempered by means of a mixing valve or combination faucet for dietary services staff use. Any self-closing, slow-closing, or metering faucet shall be designed to provide a flow of water for at least 15 seconds without the need to reactivate the faucet. Effective with the promulgation of these requirements, an additional lavatory shall be provided in the dishwasher area in newly constructed hospices or in existing hospices undergoing major dietary alterations.

f. No staff, including dietary staff, shall store personal items within the food preparation and storage areas.

g. Dietary staff shall use good hygienic practices. Staff with communicable diseases or infected skin lesions shall not have contact with food if that contact may transmit the disease.

h. Toxic items such as insecticides, detergents and polishes shall be properly stored, labeled and used in accordance with manufacturer's guidelines.

i. Garbage and refuse shall be kept in durable, easily cleanable, insect and rodent-proof containers that do not leak and do not absorb liquids. Containers used in food preparation and utensil washing areas shall be kept covered after they are filled.

AUTHORITY NOTE: Promulgated in accordance with R.S. 40:2181-2191.

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§8257. Pharmaceutical Services of Inpatient Hospice

A. The hospice shall provide pharmaceutical services that meets the needs of the patients.

B. The hospice shall ensure that pharmaceutical services are provided by appropriate methods and procedures for the storage, dispensing and administering of drugs and biologicals. Whether drugs and biologicals are obtained from community or institutional pharmacists or stocked by the facility, the hospice facility is responsible for ensuring that pharmaceutical services are provided in accordance with accepted professional principles and appropriate federal, state, and local laws.

C. If a pharmacy is to be constructed within the hospice inpatient facility, plans shall be submitted to the Board of Pharmacy for Licensing and Registration. The pharmacy shall have a pharmacy permit issued by the Louisiana Board of Pharmacy to allow ordering, storage, dispensing, and delivering of legend prescriptive orders. The hospice inpatient facility pharmacy shall have a current controlled dangerous substance license to dispense controlled substances to patients in the facility. The pharmacy shall be directed by a registered pharmacist licensed to practice in Louisiana.

D. Licensed Pharmacist. The hospice shall employ a licensed pharmacist or have a formal agreement with a licensed pharmacist to advise the hospice on ordering, storage, administration, disposal, and record keeping of drugs and biologicals.

E. Orders for Medications. A licensed medical practitioner's order shall be obtained for all medication administered to the patient.

1. If the medication order is verbal, the licensed medical practitioner shall give it only to a licensed nurse, pharmacist, or another physician; and the individual receiving the order shall record and sign it immediately.

2. All orders (to include telephone and/or verbal) are to be signed by the prescribing licensed medical practitioner in a timely manner, not to exceed 30 days.

F. Administering Medications. Patients shall be accurately identified prior to administration of a medication.

1. Medications are administered only by a physician, a licensed nurse; or the patient, if his/her attending licensed medical practitioner has approved self-administration.

2. Orders shall be checked at least daily to assure that changes are noted.

3. Drugs and biologicals are administered as soon as possible after dose is prepared for distribution, not to exceed 2 hours.

4. Each patient has an individual medication administration record (MAR) on which the dose of each medication administered shall be properly recorded by the person administering the medication to include:

a. name, strength, and dosage of the medication;

b. method of administration to include site, if applicable;

c. times of administration;

d. the initials of persons administering the medication, except that the initials shall be identified on the MAR to identify the individual by name;

e. medications administered on a "PRN" or as needed basis shall be recorded in a manner as to explain the reason for administration and the results obtained. The Hospice shall have a procedure to define its methods of recording these medications;

f. medications brought to the hospice by the patient or other individuals for use by that patient shall be accurately identified as to name and strength, properly labeled, stored in accordance with facility policy and shall be administered to the patient only upon the written orders of the attending licensed medical practitioner;

g. medications shall not be retained at the patient's bedside nor shall self-administration be permitted except when ordered by the licensed medical practitioner. These medications shall be appropriately labeled and safety precautions taken to prevent unauthorized usage;

h. medication errors and drug reactions are immediately reported to the director of nurses, pharmacist and the licensed medical practitioner, and an entry made in the patients' medical record and on an incident report in accordance with facility policy. This procedure shall include recording and reporting to the licensed medical practitioner the failure to administer a medication, for any other reason than refusal of a patient to take a medication. The refusal of a patient to take a medication should be reported during IDT conferences. If there is adverse consequence resulting from the refusal, this is to be immediately reported to the director of nurses, pharmacist and licensed medical practitioner, and an entry made in the patients' medical record and on an incident report in accordance with facility policy;

i. the nurse's station or medicine room for all hospice inpatient facilities shall have readily available items necessary for the proper administration and accounting of medications;

j. each hospice shall have available current reference materials that provide information on the use of medications, side effects and adverse reactions to drugs and the interactions between drugs.

G. Conformance with Medication Orders. Each hospice inpatient facility shall have a procedure for at least quarterly monitoring of medication administration. This monitoring may be accomplished by a registered nurse or a pharmacist, to assure accurate administration and recording of all medications.

1. Each hospice shall establish procedures for release of patient's own medications upon discharge or transfer of the patient.

2. Medications shall be released upon discharge or transfer only upon written authorization of the attending licensed medical practitioner.

3. An entry of such release shall be entered in the medical record to include medications released, amounts, who received the medications and signature of the person carrying out the release.

H. Storage of Drugs and Biologicals. Procedures for storing and disposing of drugs and biologicals shall be established and implemented by the inpatient hospice facility.

1. In accordance with state and federal laws, all drugs and biologicals are stored in locked compartments under proper temperature controls and only authorized personnel have access to the keys. Separately locked compartments are provided for storage of controlled drugs listed in schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 and other drugs subject to abuse, except under single unit package drug distribution systems in which the quantity stored is minimal and a missing dose can be readily detected.

2. Controlled drugs no longer needed by the patient are disposed of in compliance with state requirements.

3. There shall be a secure drug or medicine room/drug preparation area at each nurses' station of sufficient size for the orderly storage of medications, both liquid and solid dosage forms and for the preparation of medications for patient administration within the unit. In the event that a drug cart is used for storage and administration of medication, the room shall be of sufficient size to accommodate placement of the cart.

4. There shall be a separate area or cubicle for the storage of each patient's medication, except where a cart is used for the administration of drugs and biologicals.

5. There shall be an operable sink provided with hot and cold water in or near the medicine room or medication preparation area for washing hands or cleaning containers used in medicine preparation. Paper towels and soap dispenser shall be provided.

6. Sufficient artificial lighting shall be provided and the temperature of the medicine storage area shall not be lower than 48 degrees Fahrenheit or above 85 degrees Fahrenheit and the room shall be provided with adequate ventilation.

7. Drugs and biologicals, including those requiring refrigeration, shall be stored within the medicine room or shall have separate locks if outside the medicine room. The refrigeration shall have a thermometer and be capable of maintaining drugs at the temperature recommended by the manufacturer of the drug.

8. No foods may be stored in the same storage area (i.e., cupboard, refrigerator, or drawer) with drugs and biologicals. The areas designated for drug and biological storage should be clearly marked.

9. Medication refrigerators shall not be used to store laboratory solutions or materials awaiting laboratory pickup.

10. The drug or medicine rooms shall be provided with safeguards to prevent entrance of unauthorized persons including locks on doors and bars on accessible windows.

a. Only authorized, designated personnel shall have access to the medicine storage area.

b. External use only drugs shall be plainly labeled and stored separate from drugs and biologicals. No poisonous substance shall be kept in the kitchen, dining area, or any public spaces or rooms. This Section shall not prohibit storage within the drug or medicine room of approved poisonous substances intended for legitimate medicinal use, provided that such substances are properly labeled in accordance with applicable federal and state law.

11. First aid supplies shall be kept in a place readily accessible to the person or persons providing care in the inpatient hospice.

12. Each hospice may maintain one "STAT" medicine cabinet for the purpose of keeping a minimum amount of stock medications that may be needed quickly or after regular duty hours. The following rules apply to such a cabinet.

a. The contents of the "STAT" medicine cabinet shall be approved by the hospice pharmacist and members of the medical and clinical staff responsible for the development of policies and procedures.

b. There shall be a minimum number of doses of any medication in the "STAT" cabinet based upon the established needs of the hospice.

c. There shall be a list of the contents of the "STAT" medicine cabinet, including the name and strength of the drug and the quantity of each.

d. There shall be records available to show amount received, name of patient and amount used, prescribing licensed medical practitioner, time of administration, name of individual removing and using the medication, and the balance on hand.

e. There shall be written procedures for utilization of the "STAT" medicine cabinet with provisions for prompt replacement of used items.

f. The pharmacist shall inspect the "STAT" medicine cabinet at least monthly, replacing outdated drugs and reconciliation of its prior usage. Information obtained shall be included in a monthly report.

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