Subpart 3. Standards for Payment

Chapter 101. Standards for Payment for Nursing Facilities

Subchapter A. Abbreviations and Definitions

§10101. Definitions

A. This glossary contains a comprehensive list of abbreviations and definitions used in the requirements for payment for nursing facilities.

Abuse—the infliction of physical or mental injury or causing deterioration to such an extent that the resident's health, moral, and/or emotional well being is endangered. Cause of such deterioration my include but is not limited to the following: sexual abuse, exploitation, extortion of funds or other things of value, negligence.

Admission—the date a person enters the facility and is admitted as a resident.

Advance Directives—an instruction, such as a living will or durable power of attorney for health care, recognized under state law relating to the provisions of health care when the individual is incapacitated. Although usually done in writing state law provides that under some circumstances these directives may be orally.

Ancillary Services—services provided at or through the facility in addition to nursing services provided which includes, but is not limited to, podiatry, dental, audiology, vision, physical therapy, occupational therapy, psychological, social and planning services.

Applicant—an individual whose written application for Medicaid certification has been submitted to the agency but whose eligibility has not yet been determined.

Assistant Director of Nursing (ADON)—a licensed nurse responsible for providing assistance to the director of nursing (DON) in a nursing facility with a licensed bed capacity of 101 or more.

Attending Physician—a physician, currently licensed by the Louisiana State Board of Medical Examiners, designated by the resident or responsible party as responsible for the direction of overall medical care. This term shall also apply to any physician providing medical care for a resident in the absence of the resident's *attending physician*.

Bed Capacity—the total number of beds which can be set up in a nursing facility for the use of residents, based on bedroom criteria of square footage. The term "bed capacity" shall include isolation beds.

a. *Certified Beds*—beds certified for use for title XVIII/XIX by DHH/BHSF.

b. *Licensed Beds*—beds licensed for use by DHH/BHSF.

Bureau of Health Services Financing (BHSF)—the division within the Office of the Secretary of the Department of Health and Hospitals responsible for the administration of the Medicaid Program.

Call System—a system that audibly registers calls electronically from its place of origin (which means the resident's bed) to the place of receivership (which means the nurses' station).

Certification—a determination made by the Louisiana Department of Health and Hospitals, Bureau of Health Services Financing, Health Standards Section that a facility meets the necessary requirements to participate in Louisiana as a provider of Title XVIII (Medicare) and/or Title XIX (Medicaid) as a nursing facility.

Certified Nursing Assistant (CNA)—an individual who has completed an approved course taught by a qualified

instructor consisting of at least 40 hours classroom and 40 hours clinical and taken a state approved written/competency. As of 1/1/90, all employed nurse aides must meet these qualifications, and aides employed after that date must complete the approved course within four months of the date of employment.

Change of Ownership (CHOW)—any change in the legal entity responsible for the operation of a nursing facility.

Charge Nurse—an individual who is licensed by the state of Louisiana to practice as an RN or LPN.

Chemical Restraint—the use of any medication listed in the schedules of legend drugs under Louisiana Revised Statute 40:964 as a substance having a depressant effect on the brain or central nervous system activity in order to prohibit inappropriate movement or behavior.

Code of Federal Regulations (CFR)—a publication by the federal government containing nursing requirements which facilities must comply with to receive payment under the Medicare/Medicaid Programs.

Comfortable Temperature—the capability to maintain a temperature for all seasons between 71 degrees and 81 degrees throughout the facility.

Continued Stay—a request for medical certification beyond the date of the currently authorized period.

Controlled Drugs—drugs listed as being subject to the Comprehensive Drug Abuse Prevention and Control Act of 1970.

Dentist—an individual currently licensed to practice dentistry in Louisiana under the provisions of current state statutes.

DHH—abbreviation for the Department of Health and Hospitals in Louisiana.

DHHS—abbreviation for the United States Department of Health and Human Services in Washington, D.C.

Dietary Manager(DM)—an individual who is a qualified dietician or a qualified food serve supervisor.

Dietitian (Qualified Consultant)—an individual certified as a registered *dietitian* by the Commission on Dietetic Registration and who is currently licensed by the Louisiana Board of Examiners in Dietetics and Nutrition.

Director of Nursing (DON)—a registered nurse licensed and registered by the state of Louisiana who directs and coordinates nursing services in a nursing facility.

Drill—the act or exercise of training employees to be familiar with the emergency actions and signals required under varied conditions.

Drug Administration—an act in which a single dose of a prescribed drug or biological is given to a resident by an authorized person in accordance with all laws and regulations governing such acts. The complete act of administration entails removing an individual dose from a previously dispensed, properly labeled container (including a unit dose container), verifying it with the physician's orders, giving the individual dose to the proper resident, and promptly recording the time and dose given.

Drug Dispensing—an act which entails the interpretation of an order for a drug or biological and, pursuant to the order, the proper selection, measuring, labeling, packaging, and issuance of the drug or biological for a resident or for a service unit of the facility by a licensed pharmacist, physician or dentist.

Existing Buildings—for purposes of ANSI standard No. A 117.1 and minimum patient room size [see 405.1134 (c) and (e)] in nursing facilities or parts thereof whose construction plans are approved and stamped by the appropriate state agency responsible therefore before October 28, 1971.

Facility—an institution which provides services to residents which includes a Medicare skilled nursing *facility* (SNF), a swing bed hospital, and/or a nursing *facility* (NF).

Facility Administrator—an individual currently licensed and registered with the Board of Examiners for Nursing Facility Administrators and is engaged in the daily administration of a nursing facility.

Fiscal Intermediary—the private fiscal agent with which DHH contracts to operate the Medicaid management information system (MMIS). It processes the title XIX (Medicaid) claims for services provided under the Medicaid Program and issues appropriate payment.

Governing Body—board of directors, board of trustees, or any other comparable designation of an individual or group of individuals who have the purpose of owning, acquiring, constructing, equipping, operating and/or maintaining a nursing facility and exercising control over the affairs of said nursing facility.

Health Care Financing Administration (HCFA)—a division under DHHS responsible for administering the Medicare Program and overseeing and monitoring the state's Medicaid Program.

HSS—Health Standards Section of the Bureau of Health Services Financing.

Licensed Practical Nurse (LPN)—an individual currently licensed by the Louisiana State Board of Nurse Examiners for Practical Nurses.

Long Term Care (LTC)—*long term care* is a set of health care, personal care, and social services delivered over a sustained period of time to persons who have lost, or never acquired, some degree of physical or cognitive capacity, as measured by an index of functional ability.

MAR—abbreviation for medication administration record.

MDS—abbreviation for minimum data set.

Medicaid—*Medicaid* assistance provided under the state plan approved under title XIX of Social Security Act.

Medicaid Agency—the single state agency responsible for the administration of the Medicaid Program. In Louisiana, the Department of Health and Hospitals is the single state agency.

Medical Director—a physician licensed in Louisiana who directs and coordinates medical care in a nursing facility.

Medical Record Practitioner (MRP)—qualified consultant. A person who:

a. is eligible for certification as a registered record administrator (RRA), or an accredited record technician (ART), by the American Record Association under its requirements in effect on the publication of this provision; or

b. is a graduate of a school of medical record science that is accredited jointly by the Council on Medical Education of the American Medical Association and the American Medical Record Association.

Misappropriation of Resident Property—to take possession of, without permission, a resident's personal belongings.

Neglect—*neglect* is defined as the facility's of employee's failure to provide the proper or required medical care, nutrition, or other care necessary for an applicant/resident's well-being.

Non-Nursing Personnel—facility staff not assigned to give residents direct personal care. This includes administrators, secretaries, activity coordinators, social services designers, bookkeepers, cooks, janitors, maids, laundry workers, and yard maintenance workers.

Nursing Facility (NF)—the term “nursing facility" or "home" shall mean a private home, institution, building, residence, or other place serving two or more persons who are not related by blood or marriage to the administrator, whether operated for profit or not, and including those places operated by a political subdivision of the State of Louisiana which undertakes, through its ownership or management, to provide maintenance, personal care, or nursing for persons who, by reason of illness or physical infirmity or age, are unable to properly care for themselves. The term does not include the following:

a. a home, institution, or other place operated by the federal government or agency, thereof, or by the State of Louisiana;

b. a hospital, sanitarium, or other medical institution whose principal activity or business is the diagnosis, care, and treatment of human illness through the maintenance and operation of organized facilities thereof;

c. a hospital, sanitarium, or other institution whose principal activity or business is the care and treatment of persons suffering from tuberculosis or from mental diseases;

d. any municipal, parish, or private child welfare agency, maternity hospital, or lying-in-home required by law to be licensed by some other department or agency;

e. any sanitarium or institution conducted by and for Christian Scientists who rely on the practice of Christian Science for treatment and healing.

Nursing Personnel—registered nurses, registered nurse applicants, graduate practical nurses, licensed practical nurses, clinical nurse associates, and ward clerks.

PASAAR—acronym for pre-admission screening and annual resident review.

Pharmacist—a person who:

a. is licensed as a *pharmacist* by the state in which he or she is practicing; and

b. has training or experience in the specialized functions of institutional pharmacy, such as residencies in hospital pharmacy, seminars on institutional pharmacy, and related training programs.

Physical Restraint—any manual method, physical or mechanical device material or equipment attached or adjacent to the resident's body that the individual cannot remove easily which restricts freedom of movement or normal access to the body. It may include a geriatric chair, a locked room unless requested by the resident, bedrails, or any facility practice that meets the definition of a restraint.

Physician—an individual currently licensed by the Louisiana State Board of Medical Examiners.

Plan of Care—the coordinated, integrated treatment plan developed for each resident. It includes each discipline's approach to a specific problem/need, i.e., physician, nursing, social activities, dietary, rehabilitative, etc. Each discipline's approach is a component of the overall plan of care, e.g., social services component of the overall plan of care.

RAI—abbreviation for resident assessment instrument.

RAPS—abbreviation for resident assessment protocol summary.

Recipient—an individual who has been determined eligible for Medicaid.

Regional Health Standards Section—a team of Bureau of Health Services Financing professional staff responsible for conducting licensing and Medicare/Medicaid certification/recertification surveys in nursing facilities, as well as, complaint investigations, and other on-site inspections as needed. These professionals are also responsible for admission review functions in the title XIX nursing facilities and the determination of the medical necessity for levels of care for Medicaid applicants/recipients.

Registered Nurse (RN)—an individual currently licensed by the Louisiana State Board of Nurse Examiners for Registered Nurses. This includes *registered nurse* applicants.

Representative Payee—an individual designated by the Social Security Administration to receive and disburse benefits in the best interest of and according to the needs of the resident.

Resident—an individual admitted to the nursing facility by and upon the recommendation of a physician and who is to receive the medical and nursing care ordered by the physician.

Resident Activities Director (RAD)—an individual certified as a *resident activity director* to direct the activity services of the nursing facility.

SNF—abbreviation for skilled nursing facility (Medicare only).

Social Service Designee (SSD)—an individual responsible for arranging or directly providing medically-related social services. (See responsibilities and qualifications under social services section.)

Sponsor—an adult relative, friend, or guardian of a resident who has an interest or responsibility in the resident's welfare.

Staffing—a joint meeting of the resident/responsible party and the facility's staff members involved in planning and implementing the overall plan of care.

SW—abbreviation for social worker.

Vendor Number—a seven digit number assigned to a licensed and certified provider who has enrolled with the state to participate in the Medicaid Program and receive payment for services rendered.

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Subchapter B. General Provisions

§10103. Certification

A. Certification of title XVIII (Medicare)/ skilled nursing facilities (SNF). DHH shall obtain a certification notice from the Secretary of the Department of Health and Human Services (DHHS) that verifies a skilled nursing facility is qualified to participate in the Title XVIII Program. The facility shall request a certification packet from BHSF/HSS state office.

B. Certification of Title XIX (Medicaid)/Nursing Facilities (NF)

1. To participate in title XIX (Medicaid Program), a nursing facility must have facility need review approval, be enrolled as a provider, and be in compliance with the requirements for participation established by federal regulations. A nursing facility may participate in the Medicaid program by meeting the requirements.

2. A facility must obtain licensure of the beds prior to or in conjunction with the request for certification of beds. Licensure of beds is performed by BHSF/HSS. For Medicaid Program participation, all beds to be certified in the Medicaid Program shall be licensed nursing facility beds.

3. Instructions and forms are contained in the packet for the NF to follow to initiate the certification process. These include but are not limited to the following.

4. Facility Need Review. Facility need review approval must be obtained for Medicaid participation. The facility shall secure approval from the Facility Need Review Program to certify that there is no cause to deny the facility from participation in the Medicaid program on the basis of need. The approval shall designate the appropriate name of the legal entity operating the facility and the number of beds eligible for Medicaid program enrollment. If the approval is not issued in the complete name of the legal entity operating the facility, evidence shall be provided to verify that the legal entity which obtained the original approval is the same legal entity operating the facility.

5. Disclosure Requirement

a. As part of the certification requirement, all Medicaid Program participating facilities shall supply BHSF/HSS with a completed Disclosure of Ownership Control Interest statement, HCFA 1513, which requires information as to the identity of the following individuals:

i. each person having a direct or indirect ownership interest in the facility of five percent or more;

ii. each owner (in whole or in part) with a five percent interest in any property, assets, mortgage, deed of trust, note, or other obligation secured by the facility;

iii. each officer and director when a facility is organized as a corporation;

iv. each partner when a facility is organized as a partnership; and

v. within 35 days from the date of request, the provider shall submit full and complete information, as specified by the BHSF, regarding the following:

(a). the ownership of any subcontractor with whom the facility has had more than $25,000 in business transactions during the previous 12 months; and

(b). information as to any significant business transactions between the facility and the subcontractor or wholly owned suppliers during the previous five years.

b. The Department of Health and Hospitals Health Standards Section shall arrange for on-site surveys for compliance with Medicaid and title VI (civil rights), life safety, and sanitation. The effective date of certification can be no earlier than the completion date of the survey, assuming all requirements are met. If requirements are not met at the time of survey, then the certification date may be delayed at the discretion of the state agency either until the facility signs an acceptable plan of correction or a follow-up visit verifies substantial compliance.

6. Change in Certification

a. A facility wishing to change its participation from Medicare/Medicaid (SNF-NF) to Medicaid (NF) or from Medicaid (NF) to Medicare/Medicaid (SNF-NF) shall submit to the Health Standards Section a letter of intent. Once the facility has been determined eligible to participate, the Medicaid Program (Medicaid) provider agreement will be amended accordingly.

b. Bed certification change - a facility wishing to change the number of beds in either category (Medicare or Medicaid) shall submit to DHH a letter of intent.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10105. Provider Enrollment

A. In order to participate as a provider of nursing services under Medicaid, a facility must meet certification requirements and enter into a provider agreement with the Department of Health and Hospitals. A provider agreement is the basis for payments by the Bureau of Health Services Financing. The execution of provider agreement and the assignment of the provider's Medicaid vendor number is contingent upon the following criteria.

1. The facility shall request a Medicaid enrollment packet from the BHSF/HSS Provider Enrollment Unit. The information listed below shall be returned as soon as it is completed.

a. Two copies of the provider agreement form which shall bear the signature of the person legally designated to enter into the contract with DHH;

b. One copy of the provider enrollment form, PE 50, which shall be completed in accordance with accompanying instructions and bear the signature of the administrator or authorized representative;

c. An addendum to the above provider agreement shall be completed if the facility chooses to provide any of the following enhanced levels of care:

i. a skilled-infectious disease (S-ID);

ii. skilled-technology dependent care (S-TDC);

iii. skilled/neurological rehabilitation treatment program (S-NRTP).

B. Effective date of the provider enrollment agreement. The effective date of the provider agreement shall be determined as follows.

1. If all federal requirements (health and safety standards) including facility need review approval requirements specified above are met on the day of the Health Standards Section survey, then the effective date of the provider agreement is the date the on-site survey is completed.

2. If all requirements as specified in one above are not met on the day of the HSS survey, then the effective date of the provider agreement is the earlier of the following dates:

a. the date on which the provider meets all requirements; and

b. the date on which the provider submits a corrective action plan acceptable to the HSS.

3. Upon receipt of the above documentation/verification, Bureau of Health Services Financing-Health Standards Section Provider Enrollment Unit will assign a vendor number for billing purposes along with the issuance of the Provider Agreement. The Fiscal Intermediary will be notified accordingly.

C. Provider Agreement Time Periods. The provider agreement shall meet the following criteria in regard to time periods.

1. It shall not exceed 14 months;

2. It shall coincide with the certification period set by the Health Standards Section Survey Unit; and

EXCEPTION: If HSS has adequate documentation showing "good cause", it may make an agreement and certification period for less than 12 months.

3. After a provider agreement expires, payment may be made to a facility for up to 30 days.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10107. Change in Ownership

A. Assignment of Agreement

1. As a temporary measure during a change of ownership, the Bureau of Health Services Financing-Health Standards Section shall automatically assign the provider agreement and certification to the new owner. The new owner shall comply with all participation prerequisites simultaneously with the ownership transfer. Failure to promptly comply with these prerequisites may result in the interruption in vendor payment. The new owner shall be required to complete a new provider enrollment application.

2. Such an assignment is subject to all applicable statutes, regulations, terms, and conditions under which it was originally issued including, but not limited to, the following:

a. any existing corrective action plan;

b. any expiration date;

c. compliance with applicable health and safety standards;

d. compliance with the ownership and financial interest disclosure requirements;

e. compliance with civil rights requirements;

f. any facility need review rules that are applicable;

g. compliance with any additional requirements imposed by the Bureau of Health Services Financing, Health Services Section.

B. Continued Participation. For a facility to remain eligible for continued participation after a change of ownership, the facility shall meet all the following criteria:

1. state licensing requirements;

2. all Medicaid certification requirements;

3. Medicaid provider enrollment requirements including completion of a signed contract with DHH; and

4. compliance with title VI of the Civil Rights Act.

C. Ten Percent Withholding—Release of Payments

1. When a change of ownership occurs, a minimum of ten percent of the final vendor payment to the old legal entity is withheld pending the fulfillment of the following requirements:

a. Completion of a limited scope audit of the residents' funds account and the disposition requirements for nurse aide training funds with findings and any recommendations of a qualified accountant of the old legal entity's choice submitted to the BHSF Institutional Reimbursement Section. Old legal entities have 60 days to submit the audit findings to the Bureau of Health Services Financing Institutional Reimbursement Section once the section notifies the old owner that a limited scope audit is required. Failure of the old legal entity to comply is considered a class E violation and will result in fines as outlined in the Subchapter L entitled Sanctions.

b. The facility's compliance with the recommendations of the limited scope audit and the disposition requirements for nurse aide training funds with the following two exceptions.

i. If the new legal entity disputes the findings of the limited scope audit, said entity may engage an independent auditor and submit any findings and recommendations to the BHSF Institutional Reimbursement Section for review. In such instances, the independent auditor must certify his independence and submit a written opinion to the Bureau of Health Services Financing Institutional Reimbursement Section.

ii. New owners may provide the Bureau of Health Services Financing- Health Standards Section with a notarized document attesting that they shall be responsible for completion of and compliance with the limited scope audit and the disposition requirements for nurse aide training funds. New owners have 60 days to submit the audit findings to Bureau of Health Services Financing Institutional Reimbursement Section once the section notifies the new owner that a limited scope audit is required.

NOTE: Failure of the new owner to comply is considered a class E violation and will result in fines as outlined in the Subchapter L entitled Sanctions.

c. Submittal of an acceptable cost report by the old legal entity to Bureau of Health Services Financing Program Operations Section covering the period to the date of ownership change.

2. Once these requirements are met, the portion of the payment withheld shall be released by the Bureau of Health Services Financing Program Operations Section.

NOTE: If a SN-ID or SN-TDC changes ownership, the ten percent will not be released until the above requirements are met and after cost settlement.

D. Notification to Fiscal Intermediary. Upon notification of the ownership transfer and the new owner's licensure, the Bureau of Health Services Financing- Health Standards Section Provider Enrollment Unit shall notify the fiscal intermediary regarding the effective dates of payment and to whom payment is to be made.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10109. Withdrawal from the Medicaid Program

A. A facility may involuntarily or voluntarily lose its participating status in the Medicaid Program. When a facility loses its participating status in the Medicaid Program, a minimum of ten percent of the final vendor payment to the facility is withheld pending the fulfillment of the following requirements:

1. completion of a limited scope audit of the residents' funds account and the disposition requirements for nurse aide training funds with findings and any recommendations of a qualified accountant of the facility's choice submitted to the BHSF Institutional Reimbursement Section. The facility has 60 days to submit the audit findings to the BHSF Institutional Reimbursement Section once the section notifies the facility that a limited scope audit is required. Failure of the facility to comply is considered a class E violation and will result in fines as outlined in the Subchapter L entitled sanctions;

2. the facility's compliance with the recommendations of the limited scope audit and the disposition requirements for nurse aide training funds;

3. submittal of an acceptable final cost report by the facility to BHSF Program Operations Section.

B. Once these requirements are met, the portion of the payment withheld shall be released by BHSF Program Operations.

NOTE: If a SN-ID or SN-TDC withdraws from the Medicaid Program, the 10 percent will not be released until the above requirements are met and after cost settlement.

C. In situations where a facility either voluntarily or involuntarily discontinues its operations or participation in the Medicaid Program, residents, residents legal representative or sponsor, and other appropriate agencies or individuals shall be notified as far in advance of the effective date as possible to ensure an orderly transfer and continuity

of care. The owner or administrator shall submit written notice of withdrawal to BHSF/HSS at least 30 days in advance of a voluntary withdrawal.

D. If the facility is closing its operations, plans shall be made for transfer. If the facility is voluntarily or involuntarily withdrawing from Medicaid Program participation, the resident has the option of remaining in the facility on a private-pay basis.

E. Payment Limitation

1. Payments may continue for residents up to 30 days following the effective date of the facility's certification of non-compliance.

2. The payment limitation also applies to Medicaid applicants and recipients admitted prior to the certification of non-compliance notice.

3. Payment is continued only if the facility totally cooperates in the orderly transfer of applicants/recipients to other Medicaid facilities or other placements of their choice.

NOTE: The facility shall not admit new Medicaid applicants/recipients after receiving the certification of non-compliance notice. There shall be no payment approved for such an admittance.

4. DHH may cancel the provider agreement if and when it is determined that the facility is in material breach of contract.

F. Facility Certification of Non-Compliance

1. When the DHH Bureau of Health Services Financing, Health Standards Section determines that a facility no longer meets state and federal Medicaid certification requirements, action is taken. Usually an advance certification of non-compliance date is set unless residents are in immediate danger.

2. Certification of Non-Compliance Notice

a. On the date the facility is notified of its certification of non-compliance, DHH shall immediately begin notifying residents, residents legal representative or sponsor, and other appropriate agencies or individuals of the action and of the services available to ensure an orderly transfer and continuity of care.

b. The process of certification of non-compliance requires concentrated and prompt coordination among the following groups:

i. the BHSF Health Standards regional office;

ii. the parish office of DHH BHSF, Medicaid Program;

iii. the facility; and

iv. other offices as designated by DHH.

c. This coordination effort shall have the following objectives:

i. protection of residents;

ii. assistance in finding the most appropriate placements when requested by residents and/or responsible parties; and

iii. timely termination of vendor payment upon the resident's discharge from the facility.

NOTE: The facility still retains its usual responsibility during the transfer/discharge process to notify the parish office of DHH/BHSF Medicaid Program promptly of all changes in the resident's status.

3. Transfer Team. DHH shall designate certain staff members as a transfer team when a mass transfer is necessary. Their responsibilities shall include supervising transfer activities in the event of a proposed facility certification of non-compliance with Medicaid participation. The following procedures shall be taken by or under the supervision of this team.

a. Supervision and Assistance. When payments are continued for up to 30 days following certification of non-compliance, the transfer team shall take the following actions:

i. supervise the facility certification of non-compliance and transfer of its Medicaid residents;

ii. determine the last date for which vendor payment for resident care can be made; and

iii. assist in making the most appropriate arrangements for the residents, providing the team members' names as contact persons if such help is needed.

b. Effecting the Transfer. To ensure an orderly transfer or discharge, the transfer team shall also be responsible for performing the following tasks:

i. they shall meet with appropriate facility administrative staff and other personnel as soon as possible after termination of a provider agreement to discuss the transfer planning process;

ii. they shall identify any potential problems;

iii. they shall monitor the facility's compliance with transfer procedures;

iv. they shall resolve disputes in the resident's best interest; and

v. they shall ensure that the facility takes an active role in the transfer planning.

vi. the local ombudsman and advocacy agencies shall be notified.

Note: The facility's failure to comply with the transfer team's requests may result in denial of reimbursement during the extension period.

c. Provisions for Resident Services During Transfer or Discharge. DHH has the following responsibilities:

i. to provide social services necessary in the transfer or discharge plan or otherwise necessary to ensure an orderly transfer or discharge in accordance with the State Plan of the Medicaid Program; and

ii. to obtain other services available under Medicaid.

d. Parish DHH/BHSF Medicaid Program Responsibilities: Applicant/Recipient Status Listing. The parish office of DHH/BHSF Medicaid Program shall maintain a listing of each applicant/recipient's status as authorization forms are submitted regarding transfer or discharge. At the conclusion of the 30 day period referred to above, the transfer team shall submit a report to the office of DHH/BHSF Medicaid Program, outlining arrangements made for all Medicaid applicants/recipients.

e. Resident Rights. Nothing in the transfer or discharge plan shall interfere with the existing bill of rights.

G. Recertification of an Involuntary Withdrawal. After involuntary certification of non-compliance, a facility cannot participate as a provider of Medicaid services unless the following conditions are met:

1. the reasons for the certification of non-compliance of the contract no longer exist;

2. reasonable assurance exists that the factors causing the certification of non-compliance will not recur;

3. the facility demonstrates compliance with the required standards for a 60 day period prior to reinstatement in a participating status; and

4. the initial survey verifies that residents are receiving proper care and services;

5. certification requirements for swing bed hospitals. Small rural hospitals may certified to provide Medicaid nursing facility services if all of the following conditions are met:

a. the hospital has a valid agreement as a title XVIII (Medicare) provider of swing bed services;

b. the hospital has fifty hospital beds or fewer, excluding beds for newborns and beds in intensive care type in residents units;

c. the hospital is located in an area not designated as "urban" in the most recent census;

d. a facility need review approval has been granted;

e. the hospital is not operating under a waiver of the hospital requirements for 24 hour nursing services;

f. the hospital has a valid title XIX (Medicaid) agreement as a provider of acute care hospital services;

g. the hospital has not had a swing bed title XVIII (Medicare) or Title XIX (Medicaid) approval terminated within two years previous to application;

h. a provider of swing bed services shall comply with conditions for title XIX (Medicaid) participation as both acute care hospital and Medicaid nursing facility; however, a lack of compliance with nursing facility requirements does not affect participation as a provider of acute care hospital services;

i. hospitals seeking to enroll as swing bed facilities on or after July 9, 1987 shall also meet the following criteria:

i. possess a current nursing home license;

ii. be administered by a licensed Nursing Home Administrator;

iii. meet the need and resource goals as established in facility need review regulations; and

iv. list enrollment to ten percent of bed capacity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

Subchapter C. Administration

§10111. Introduction

A. A facility shall be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. It shall be responsible for ensuring that all services provided to the residents by professional staff meet ethical and professional standards governing the profession.

B. Licensure. A facility must be licensed under applicable state and local laws.

C. Compliance with Federal, State, and Local Laws and Professional Standards. The facility must operate and provide services in compliance with all applicable federal, state and local laws, regulations and codes, and with accepted professional standards and principles that apply to professionals providing services in such a facility.

D. Relationship to Other HSS Regulations. In addition to compliance with the regulations set forth in this sub-part, facilities are obliged to meet the applicable provisions of other HSS regulations, including but not limited to those pertaining to:

1. nondiscrimination on the basis of race, color, or national origin (45 CFR page 80);

2. nondiscrimination on the basis of handicap (45 CFR page 84);

3. nondiscrimination on the basis of age (45 CFR Part 91);

4. protection of human subjects of research (45 CFR page 46); and

5. fraud and abuse (42 CFR Part 455).

E. Although these regulations are not in themselves considered requirements under this part their violation may result in termination or suspension of, or the refusal to grant or continue payment with federal funds.

F. Nursing facilities shall meet the following criteria.

1. Compliance. Facilities shall be in compliance with title VI of the Civil Rights Act of 1964 and shall not discriminate, separate, or make any distinction in housing, services, or activities based on race, color, or national origin.

2. Community Notification. Facilities shall notify the community that admission to the facility, resident care services, and other activities are provided without regard to race, color, or national origin. Notice to the community may be physicians, local health and welfare agencies, paramedical personnel, and public and private organizations having interest in equal opportunity or by notices in the local newspaper.

a. Residents shall not be asked if they are willing to share a room with a person of another race, color, or national origin.

b. Resident transfers shall not be used to evade compliance with title VI of the Civil Rights Act of 1964.

3. Open Admission Policy. An open admission policy and desegregation of facilities shall be required, particularly when the facility previously excluded or primarily served residents of a particular race, color, or national origin. Facilities which exclusively serve residents of one race have the responsibility for taking corrective action, unless documentation is provided that this pattern has not resulted from discriminatory practices.

4. Restricted Occupancy. A facility owned or operated by a private organization may restrict occupancy to members of the organization without violating Civil Rights compliance, provided membership in the organization and admission to the facility is not denied on the basis of race, color, or national origin.

5. Resident Services. All residents shall be provided medical, non-medical, and volunteer services without regard to race, color, or national origin. All administrative, medical and non-medical services are covered by this requirement.

6. Facility Personnel. Attending physicians shall be permitted to provide resident services without regard to race, color, or national origin.

a. Other medical, paramedical, or non-medical persons, whether engaged in contractual or consultative capacities, shall be selected and employed in a non-discriminatory manner.

b. Opportunity shall not be denied to qualified persons on the basis of race, color, or national origin.

c. Dismissal from employment shall not be based upon race, color, or national origin.

G. Facilities shall comply with section 504 of the Rehabilitation Act of 1973 which states the following: No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from federal financial assistance.

H. Governing Body. The facility must have a governing body or designated persons functioning as a governing body that is legally responsible for establishing and implementing policies regarding the management and operation of the facility.

1. The governing body appoints the administrator who is:

a. licensed by the state where licensing is required; and

b. responsible for management of the facility.

I. Staffing. There are staff sufficient in number and qualifications on duty all hours of each day to carry out the policies, responsibilities, and program of the facility. The numbers and categories of personnel are determined by the number of residents and their particular needs in accordance with guidelines in this manual.

J. Policies and Procedures. There are written policies and procedures available to staff, residents, and the public which govern areas of service provided by the facility.

K. In-service Education Program. There is an orientation program for all new employees that includes review of all facility policies. Each employee receives appropriate orientation to the facility and its policies and to his position and duties. An in-service education program is planned and conducted for the development and improvement of skills of all the facility's personnel. In-service training includes at least prevention and control of infections, fire prevention and safety, accident prevention, confidentiality of resident information, and preservation of resident dignity, including protection of his privacy and his personal and privacy rights. Records are maintained which indicate the content of and attendance at such staff development programs.

1. Ongoing educations programs include orientation and in-service training appropriate for each employee.

2. Records indicate content and attendance at staff development programs.

L. Personnel Policies and Procedures. The governing body, through the administrator, is responsible for implementing and maintaining written personnel policies and procedures that support sound resident care and personnel practices. Personnel records are current and available for each employee and contain sufficient information to support placement in the position to which assigned. Written policies for control of communicable diseases are in effect to ensure that employees with symptoms or signs of communicable disease or infected skin lesions are not permitted to work and that a safe and sanitary environment for residents and personnel exists and incidents and accidents to residents and personnel are reviewed to identify health and safety hazards. Employees are provided or referred for annual health evaluations.

M. Development and Review of Resident Care Policies. The administrator or his designee is responsible, in writing, for the execution of such policies.

N. Quality Assurance. Each facility must have a quality assessment and assurance committee. Members must include:

1. director of nursing services;

2. physician designated by facility; and

3. at least three other members of the facility staff.

a. This committee meets at least quarterly to identify issues with respect to which quality assessments and assurance activities are necessary.

b. This committee develops and implements appropriate plans of action to correct identified quality deficiencies.

c. DHH or DHHS may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section.

d. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions and/or citations on Form 2567.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10113. Infection Control

A. The facility must establish and maintain an infection control program designed to provide a safe, sanitary, and comfortable environment in which residents reside and to help prevent the development and transmission of disease and infection using Centers for Disease Control guidelines where available.

B. Infection Control Program (ICP). An ICP must be established in the facility which identifies who:

1. investigates, controls, and prevents infections in the facility;

2. decides what procedures, such as isolation, should be applied to an individual resident; and

3. maintains a record of incidents and corrective actions related to infections.

C. Preventing Spread of Infection

1. When the staff members designated by the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident.

2. The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food if direct contact will transmit the disease.

3. The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional standards.

4. Personnel must handle, store, process, and transport linens so as to prevent the spread of infection.

5. Universal precautions shall be used for residents regardless of diagnosis and/or condition.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10115. Physical Environment and Sanitation

A. The facility must be designed, constructed, equipped, and maintained to protect the health and safety of residents, personnel, and the public as set forth below.

B. Favorable Environment for Residents. Resident living areas are designed and equipped for the comfort and privacy of the resident. Each room is equipped with or conveniently located near adequate toilet and bathing facilities appropriate in number, size, and design to meet the needs of residents. Each resident room contains a suitable bed and functional furniture appropriate to the residents needs.

C. Hot Water. An adequate supply of hot water for resident use is available. Temperature of hot water at plumbing fixtures used by residents is automatically regulated by control valves to assure a temperature between 110 degrees and 120 degrees Fahrenheit at the faucet outlet.

D. Isolation Techniques. Written effective procedures in aseptic and isolation techniques are followed by all personnel. Procedures are reviewed annually and revised when necessary for effectiveness and improvement.

E. Housekeeping. The facility employs sufficient housekeeping personnel and provides all necessary equipment to maintain a safe, clean, and orderly interior. An employee is designated full-time responsibility for this service and for supervision and training of housekeeping personnel. A facility that has a contract with an outside resource for housekeeping services may be found to be in compliance with this standard provided the facility and/or outside resources meet the requirements of the standard.

F. Maintenance of Equipment, Building, and Grounds. The facility establishes a preventive maintenance program to ensure that equipment is operative and that the interior and exterior of the building are clean and orderly. All essential mechanical, electrical, and resident care equipment is maintained in safe operating condition.

G. Nursing Unit. Each nursing unit has at least the following basic service areas: Nurses station, storage and preparation area(s) for drugs and biologicals, and utility and storage rooms that are adequate in size, conveniently located, and well lighted to facilitate staff functioning. The nurses station is equipped to register residents' calls through a communication system from resident areas, including rooms and toilet and bathing facilities.

H. Environment. The facility must provide:

1. a safe, clean, comfortable, and homelike environment, allowing the resident to use his or her personal belongings to the extent possible;

2. housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior;

3. clean bed and bath linens that are in good condition;

4. private closet space in each resident room with clothes rack and shelves and/or drawers accessible to the resident;

5. adequate and comfortable lighting levels in all areas;

6. comfortable and safe temperature levels. The facility must provide the capability to maintain a temperature for all seasons between 71 degrees and 81 degrees throughout all occupied resident areas; and

7. for the maintenance of comfortable sound levels.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

Subchapter D. Resident Care Services

§10117. Administrative Services

A. Facility Administrator. All facilities are required to have full-time administrators. "Full-time" administrators are persons who are licensed, currently registered and engaged in the day to day management of the facility. A full-time employee functioning in an administrative capacity shall be authorized in writing to act in the administrator's behalf when he/she is absent or when the administrator is functioning as a full-time administrator for two facilities. The administrator's duties shall conform to the following standards.

1. Administrative/management activities shall be the major function of the duties required. The administrator is responsible for the management of the facility.

2. An adequate and reasonable amount of time shall be spend on the premises of the facility. The activity must be the major functions of the person performing the act.

3. A major portion of the time, referred to above, shall be spent during the normal work week of the facility's personnel.

B. Restrictions

1. No individual may function as a full-time administrator for more than two nursing facilities. When a full-time administrator is engaged in the management of two nursing facilities, the facilities' sizes and proximity to one another have considerable bearing on the administrator's ability to adequately manage the affairs of both nursing facilities. The response time to either facility shall be no longer than one hour. If the administrator does serve two facilities, he must spend 20 hours per week at each facility.

2. The full-time administrator of a multi-story facility shall not function as an administrator of another nursing facility. The administrator or his designee is responsible, in writing, for the execution of all policies and procedures. If a change occurs in the individual who is the administrator of a nursing facility, notice shall be provided to BHSF Health Standards Section at the time the change occurs by the facility administrator or, in the absence of an administrator, by the governing body of the facility. Notice shall include the identity of all individuals involved and the specific changes which have occurred. Failure to provide written notice by certified mail within 30 calendar days from the date a change occurs will result in a class C civil money penalty (refer to Subchapter L, Sanctions).

D. The bureau shall allow long term care facilities 30 days from the date of change in the position to fill the resulting vacancy in the administrator position. There shall be no waiver provisions for this position. The governing body of the facility shall appoint a facility designee charged with the general administration of the facility in the absence of a licensed administrator.

E. Failure to fill a vacancy to or notify the Bureau in writing by the thirty-first day of vacancy that the administrator position has been filled shall result in a class C civil money penalty (refer to Subchapter L, Sanctions).

F. Assistant Administrator. A nursing facility with a licensed bed capacity of 161 or more beds must employ an assistant administrator. An assistant administrator shall:

1. be a full-time employee; and

2. function in an administrative capacity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996),

§10119. Physician Services

A. Medical Director. The nursing facility shall have a written agreement with a physician who shall serve as the medical director on a full-time or part-time basis. Whether the physician is employed full-time or part-time shall be based on the residents' needs.

1. The medical director shall not have peer restriction in regard to overseeing total medical care.

2. The medical director is responsible for:

a. implementation of resident care policies; and

b. coordination of medical care in the facility.

3. Residents shall be admitted to a facility only with a physician's order, and medical care shall be under a physician's supervision. Each resident shall have freedom of choice of physicians.

B. Physician Supervision; Ongoing Care. All facilities shall develop policies and procedures to ensure that each resident's health care is under a Louisiana physician's continuing supervision. Each resident must remain under the care of a physician. The care of every skilled/NRTP resident shall be under the supervision of a licensed physiatrist, certified in physical medicine and rehabilitation.

C. A physician visit is considered timely if it occurs not later than ten days after the date the visit was required. At the option of the physician, required visits after the initial visit may be made by a physician assistant, nurse practitioner or clinical nurse specialist. Otherwise, all physician visits shall be made by the physician personally. This does not relieve the physician of his/her obligation to visit a resident when the resident's medical condition makes that visit necessary.

D. Physicians may delegate tasks to a physician's assistant, nurse practitioner, of clinical nurse specialist who:

1. meets the applicable definitions as outlined in 42 CFR 491.2;

2. is acting within the scope of practice as defined by state law; and

3. is under the supervision of a physician.

E. A physician may not delegate a task when the regulations specify that the physician shall perform it personally or when the delegation is prohibited under state law or by the facility's own policies.

F. The facility shall provide or arrange for the provision of physician services 24 hours a day in case of emergency.

G. Alternate Physicians. When continuing care by the attending physician is interrupted by that physician's illness or vacation, the attending physician shall arrange for a designated attending physician to provide coverage.

H. Frequency of Visits. Physician visits shall conform to the following schedule.

1. For SNFs and NFs the resident shall be seen at least once very 30 days for the first 90 days after admission and at least once every 60 days thereafter.

I. Physician Responsibilities. The attending physician's services shall include but shall not be limited to the following:

1. making arrangements for the resident's medical care when he/she is not available;

2. performing an examination when visiting and recording the findings in the medical record;

3. reviewing a resident's total program of care, including medication treatment regiment and comprehensive care plan at least once every 90 days; and

4. signing and dating all orders;

5. ordering and/or performing the following:

a. medications;

b. diagnostic tests;

c. specialized rehabilitative services;

d. treatment procedures;

e. medical appliances;

f. psychosocial services;

g. discharge evaluations;

6. entering legible progress notes in the medical record, signing and dating his/her entry at each visit;

7. discussing new treatments, medications, and discharge potential and/or plans with the resident, if at all possible;

8. updating the medical record with any subsequent diagnosis which the resident may have acquired since admission and ensuring that all pertinent diagnoses are recorded in one place in the medical record; and

9. giving telephone orders only to physicians, pharmacists, physician's assistants and licensed nurses. The physician shall sign telephone orders within seven days;

10. ordering rehabilitative services with a written plan of care under the following conditions:

a. in consultation with appropriate therapist(s) and the nursing service staff; and

b. with progress being reviewed after the rehabilitative care plan implementation being re-evaluated with the therapist(s) as necessary but at least every 30 days.

J. Physician's Signature. Whenever a physician's signature is required, the actual signature shall be written. The physician may use initials only if an original legend sheet with a full signature and the initials which will be used is placed on the record. Use of signature stamps by physicians is allowed when the signature stamp is authorized by the individual whose signature the stamp represents. The administration office of the nursing facility should have on file a signed statement to the effect that he/she is the only one who has the stamp and uses it. There is no delegation to another individual.

1. Electronic signatures, where automated, are acceptable. Orders may be faxed if:

a. original orders are retained by the physician and provided if requested, or sent to facility at a later date; and

b. the facility should photocopy fax to prevent fading of document over time.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10121. Nursing Services

A. The facility shall provide an organized nursing service with a sufficient number of licensed and unlicensed qualified nursing personnel to meet the total nursing needs of all

residents in accordance with the resident care policies of the facility on a 24 hour basis.

1. The facility shall provide:

a. policies that are designed to ensure that each resident:

i. receives treatments, medications, diets as prescribed, rehabilitative nursing care as needed;

ii. receives care to prevent pressure sores and deformities;

iii. is kept comfortable, clean, and well-groomed;

iv. is protected from accident, injury, and infection; and

v. is encouraged, assisted, and trained in self-care and group activities.

b. Assurance that all nursing personnel are assigned duties consistent with their education and experience and based on the characteristics of the resident load; and

c. Weekly time schedules which indicate the number and classification of nursing personnel, including relief personnel who worked in each unit for each tour of duty.

B. Director of Nursing Services. all nursing facilities shall have a director of nursing (DON) who is a qualified registered nurse employed full-time and regularly assigned to the day shift.

1. The director of nursing must have, in writing, administrative authority, responsibility and accountability for the functions, activities, and training of the nursing services staff.

2. The director of nursing may serve only one facility in the capacity of director of nursing.

3. If a change occurs in the individual who is the director of nursing, notice shall be provided by the facility administrator (or governing body in absence of administrator) to BHSF/HSS at the time the change occurs. Notice shall include the identity of all individuals involved and the specific changes which have occurred. Failure to provide written notice by certified mail within 30 calendar days from the date a change occurs, will result in a Class C civil money penalty. (Refer to Subchapter L Sanctions.)

4. The Bureau shall allow long term care facilities 30 days from the date of change in the position of director of nursing to fill a resulting vacancy. In the interim, an RN must be assigned the responsibility of the DON position. Waiver of the 30 day time limit may be granted by the Bureau if:

a. The facility demonstrates to the satisfaction of the bureau that the facility has been unable, despite diligent efforts (including offering wages at the community prevailing rate for nursing facilities) to recruit a director of nursing.

b. The Bureau determines that a waiver of the director of nursing will not endanger the health and safety of individuals staying in the facility.

5. Failure to fill a vacancy or to notify the Bureau in writing that the director of nursing position (where no waiver has been granted) has been filled by the thirty-first day of vacancy (or expiration of any waiver granted) shall result in a class C civil money penalty. (Refer to Sanctions.)

6. The bureau shall retain the right to apply any other applicable remedies.

C. Assistant Director of Nursing. If the director of nursing has administrative responsibilities or the nursing facility has a licensed bed capacity of 101 or more, the facility shall have a full-time assistant director of nursing (ADON).

D. RN Coverage. A nursing facility shall use the services of an RN for at least 8 consecutive hours a day, seven days a week. When seven-day RN coverage cannot be provided, the facility must notify Health Standards Section following guidelines outlined for the separation of the director of nursing.

E. Waiver. If a facility is unable to obtain the seven-day RN coverage the facility may request a waiver. To obtain a waiver for the seven-day RN coverage, the facility shall submit a written request to the regional office which includes:

1. proof that diligent efforts have been made to recruit appropriate personnel. Newspaper invoices with the ad attached shall be submitted and the hourly salary offered and any other benefits offered;

2. names and phone numbers of RN's interviewed for the job.

a. Upon receipt of this information, the regional office will review the level of care of the residents in the facility and make a determination that approval of the waiver would/would not endanger the health or safety of the residents staying in the facility. The regional office will make a recommendation to the state office to approve/deny the waiver.

b. The facility will be notified, in writing, as to the approval/denial of the waiver by state office. Although a facility is granted a waiver, the facility shall continue to recruit for an RN on a continuous basis to fill the position.

c. A waiver approval will expire after one year or upon the next standard survey.

d. The nursing facility that is granted such a waiver by the state notifies residents of the facility (or where appropriate, the guardians or legal representatives of such residents) and members of their immediate families of the waiver.

e. When a waiver for seven-day RN coverage has been granted, the facility cannot train nursing assistants.

F. Waiver in a Skilled Nursing Facility or Dually Certified SNF/NF. The secretary of DHHS may waive the requirement that a SNF provide the services of a registered nurse for more than 40 hours a week, including a director of nursing if the secretary finds that the facility:

1. is located in a rural area and the supply of SNF services in the area is not sufficient to meet the needs of individuals residing in the area;

2. has one full-time registered nurse who is regularly on duty at the facility 40 hours a week; and

3. has only residents whose physicians have indicated through written orders that they do not require the services of a registered nurse or physician for a 48 hour period, or has made arrangements for a registered nurse or physician to spend time at the facility to provide necessary skilled nursing services on days when the regular full-time registered nurse is not on duty.

a. To apply for a waiver of registered nurse coverage in a skilled nursing facility, the provider should send a written request to: Health Care Financing Administration, Regional Office VI, 1200 Main Tower Building, Dallas, Texas 75202, attn: Mr. Mitchell Chunn.

b. Facilities providing the following levels of care may not request a waiver for seven-day RN coverage:

i. skilled—NRTP;

ii. skilled—ID; or

iii. skilled—TDC.

G. Charge Nurse. A registered nurse, or a qualified licensed practical (vocational) nurse shall be designated as charge nurse by the DON for each tour of duty and is responsible for supervision of the total nursing activities in the facility during each tour of duty.

1. A director of nursing may not serve as charge nurse in a facility with an average daily total occupancy of 60 or more residents.

2. The charge nurse delegates responsibility to nursing personnel for the direct nursing care of specific residents during each tour of duty on the basis of staff qualifications, size/physical layout of the facility, characteristics of resident load, and emotional, social, and nursing care needs of the residents.

H. Certified Nursing Assistants (CNA). A nursing facility shall not use any individual who is not a certified nursing assistant in the facility on or after October 1, 1990 for more than four months unless the individual has completed a training and competency evaluation program or competency evaluation program approved by the state agency. For additional information, refer to the Chapter on nurse aide training.

I. Clerical Staff. Effective September, 1991 all facilities shall employ two full-time clerical employees.

J. Other Nursing Services. Nursing services shall be provided to the resident to ensure that the needs of the resident are met. These services include the following:

1. Drug Administration. Medications shall be administered only by a licensed physician, licensed/applicant nurse, or the resident (with the approval of the ID team as documented in the comprehensive care plan.)

2. The facility should be cognizant of the mental status of the resident's roommate(s) or other potential problems which could result in abuses with drugs used for self-administration.

3. Medications shall be administered in accordance with the facility's established written procedures and the written policies of the pharmaceutical services committee to ensure the following criteria are met:

a. Drugs to be administered are checked against physician's orders.

b. The resident is identified before administering the drug.

c. All medications/treatments are administered and properly charted in accordance with nursing practice standards. The reason for each medication omission shall be recorded in the resident's active medical record.

i. The drug dosage shall be prepared, administered, and recorded by the same person.

ii. Medications prescribed for one resident shall not be administered to any other person.

iii. Medication errors and adverse drug reactions shall be immediately reported to the attending physician and recorded in the medical record.

iv. Current medication reference texts or sources shall be kept in all facilities.

4. Automatic Stop Orders. Medications not specifically limited as to time or number of doses when ordered shall be controlled by automatic stop orders or other methods in accordance with written policies. The attending physician must be notified of an automatic stop order prior to the last dose so that (s)he may decide if the administration of the drug or biological is to be continued or altered.

5. Self Administration. Self administration of medication is allowed only in accordance with orders of resident's attending physician, in conjunction with the ID team, when documented in the comprehensive care plan.

6. Drug Orders. Medications shall be ordered by the attending physician verbally or in writing.

a. Verbal medication orders shall be:

i. given only to a licensed/applicant nurse, pharmacist, physician's assistant, nurse practitioner, clinical nurse specialist or another physician;

ii. immediately recorded, fully dated, and signed by the individual receiving the order;

iii. fully dated and signed by the physician within seven days; and

iv. Category II controlled substances must be confirmed in writing within 72 hours and may be given only in an emergency (controlled substance as of 1970).

7. Standing orders, if used, shall be placed in each resident's record and shall be signed by the resident's attending physician and fully dated. These orders shall be reviewed, signed, and fully dated at least annually.

8. Activities of Daily Living (ADL). Based on the comprehensive assessment of a resident, the facility shall ensure that:

a. a resident's abilities in activities of daily living (ADLs) do not diminish unless circumstances of the individual's clinical condition demonstrate that diminution was unavoidable;

b. activities of daily living (ADLs) include the ability to do the following:

i. bathe, dress and groom;

ii. transfer and ambulate;

iii. toilet;

iv. eat; and

v. to use speech, language or other functional communication system.

c. A resident who is unable to carry out activities of daily living shall receive the necessary services to maintain good nutrition, grooming and personal/oral hygiene.

d. A resident is to be given the appropriate treatment and services to maintain or improve his/her functional status and abilities to perform their ADLs.

9. Vision and Hearing. The residents shall receive proper treatment and assistive devices to maintain vision and hearing abilities. The facility shall assist the resident in making appointments and arranging for transportation to and from appointments and in locating assistance from community and charitable organizations when payment is not available through Medicaid, Medicare, or private insurance.

10. Pressure Sores. A resident who enters a facility without pressure sores does not develop pressure sores unless the individual's clinical condition demonstrates that they are unavoidable. A resident having pressure sores shall receive necessary treatment and services to promote healing, prevent infection, and prevent sores from developing unless the individual's clinical condition demonstrates that they were unavoidable.

11. Urinary Incontinence. A resident who enters the facility without an indwelling catheter is not catheterized unless the resident's clinical condition demonstrates that catheterization was necessary. A resident who is incontinent of bladder receives appropriate treatment and services to prevent urinary tract infections and to restore as much normal bladder function as possible and prevent skin breakdown.

12. Restorative Nursing Care. Nursing services shall be provided in accordance with the needs of the residents and restorative nursing care is provided to each resident to achieve and maintain the highest possible degree of function, self-care, and independence. Restorative nursing care services must be performed daily for those residents who require such service.

13. Range of Motion. A resident who enters the facility with full range of motion (ROM) should not experience reduction in ROM unless the resident's clinical condition demonstrates that a reduction in range of motion is unavoidable. A resident with limited ROM must receive appropriate treatment and services to increase/maintain or prevent further decrease in range of motion.

14. Psychological Functioning. A resident who displays psychosocial adjustment difficulty shall receive appropriate treatment and services to achieve as much remotivation and reorientation as possible. A resident whose assessment did not reveal a psychosocial adjustment difficulty should not display a pattern of decreased social interaction and/or increased withdrawn, angry, or depressive behavior unless the resident's clinical condition demonstrates that such a pattern was unavoidable.

15. Naso-Gastric-Gastrostomy Tubes. A resident who has been able to eat an adequate diet with assistance should not be fed by naso-gastric (NG) tube unless the resident's clinical condition demonstrates that the use of NG tube was unavoidable.

a. A resident who is fed by NG or gastrostomy tubes shall receive the appropriate treatment and services to prevent:

i. aspiration pneumonia;

ii. diarrhea and vomiting;

iii. dehydration and metabolic abnormalities;

iv. nasal pharyngeal ulcers.

b. Feedings shall be provided to restore normal feeding function if possible.

16. Accidents. The resident's environment shall remain as free of accident hazards as possible. Each resident shall receive adequate supervision and assistive devices to prevent accidents.

17. Nutrition. Each resident shall be maintained within acceptable parameters of nutritional states such as body weight and protein levels unless the resident's clinical condition demonstrates that this is not possible. In instances where a nutritional problem has been identified, the resident shall be assessed for the need of a therapeutic diet. A therapeutic diet must be prescribed by the attending physician.

18. Hydration. Each resident must receive sufficient fluid intake to maintain proper hydration and health.

19. Special Needs. Residents must receive proper treatment and care for the following:

a. injections;

b. parenteral and enteral fluids;

c. colostomy, ureterostomy, or ileostomy care;

d. tracheostomy care;

e. tracheal suctioning;

f. respiratory care;

g. podiatric care; and

h. prosthesis.

NOTE: Resident's rights and/or advance directives may supersede the above standards.

K. Release of a Body by a Registered Nurse. In the absence of a physician in a setting other than an acute care facility, when an anticipated death has apparently occurred, registered nurses may have the decedent removed to the designated funeral home in accordance with the standing order of a medical director/consultant setting forth basic written criteria for a reasonable determination of death. This is not applicable in cases where the death was unexpected.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996), amended LR 23:970 (August 1997).

§10123. Comprehensive Assessment

A. The facility must conduct initially and periodically a comprehensive, accurate, standardized, reproducible assessment of each resident's functional capacity and needs, in relation to a number of specified areas. Comprehensive assessments must:

1. be based on a uniform data set (resident assessment instrument); and

2. describe the resident's capability to perform daily life functions and significant impairments in functional capacity;

3. include the following information:

a. medically defined conditions and prior medical treatment;

b. medical status measurements;

c. physical and mental functional status;

d. sensory and physical impairments;

e. nutritional status and requirements;

f. special treatment and procedures;

g. mental and psychosocial status;

h. discharge potential;

i. dental condition;

j. activities potential;

k. rehabilitation potential;

l. cognitive status; and

m. drug therapy.

B. Frequency. The assessment must be conducted no later than 14 days after admission for new admissions.

1. A reassessment must be completed after a significant change in the resident's physical and/or mental condition.

2. A reassessment must be conducted at least once every 12 months/annually.

3. Residents must be examined and assessments must be reviewed every three months and revised as appropriate to assure the continued accuracy of the assessment.

C. Coordination of Assessments with Pre-admission Screening. The facility must coordinate assessments with the state-required pre-admission screening program to the maximum extent practicable to avoid duplicate testing and effort.

D. Accuracy of Assessments. To assure accuracy, the assessments:

1. must be conducted or coordinated with the appropriate participation of health professional;

2. must be conducted or coordinated by a registered nurse who signs and certifies completion of the assessment; and

3. must have each individual who completes a portion of the assessment sign and certify the accuracy of that portion of the assessment.

E. Penalty for Falsification

1. Any individual who willfully and knowingly certifies (or causes another individual to certify) a material and false statement is subject to civil money penalties.

2. Clinical disagreement does not constitute a material and false statement.

3. If the state determines under survey, or otherwise, that there has been knowing and willful certification of false statements, the state may require that the residents' assessments be conducted by individuals independent of the facility. The independent assessors must be approved by the state. The total cost of this independent assessment is the sole responsibility of the facility. Additionally, all independent assessments are not considered necessary expenditures of the facility.

F. Utilization—Resident Assessment Instrument (RAI)

1. Components of comprehensive assessment (RAI):

a. minimum data set (MDS);

b. triggers legend;

c. care area assessment; and

d. utilization guidelines;

e. alteration of MDS information—MDS information collected may be altered until the twenty-first day after admission for the following reasons:

i. information not available to staff completing section because the resident is unable to provide necessary information and family members must make an appointment to participate;

ii. further observation and interaction with the resident reveals a need to alter the assessment;

iii. at admission, the resident's condition is unstable and the illness or chronic problem is controlled by the twenty-first day.

2. If the MDS must be altered up to the twenty-first day, then the assessor shall show these changes on the admission assessment and shall initial and date such amendments.

3. The MDS may not be altered after the twenty-first day. If a change has occurred, a new MDS must be completed.

4. Significant change defined:

a. deterioration in two or more activities of daily living, communication, and/or cognitive abilities that appear permanent;

b. loss of ability to freely ambulate or to use hands to grasp a small object to feed or groom oneself, such as spoon, toothbrush or comb;

c. deterioration in behavior, mood, and/or relationships that has not been reversed;

d. deterioration in a resident's health status where this change places the resident's life in danger, is associated with serious clinical complications, or is associated with an initial new diagnosis of a condition that is likely to affect the resident's physical, mental, or psychosocial well-being over a prolonged period of time;

e. onset of a significant weight loss (five percent in last 30 days or ten percent in last 180 days); and

f. a marked and sudden improvement in the resident's status.

5. Document in medical record the initial identification of a significant change in status. Once it has been determined that the resident's change in status is likely to be permanent, complete a full comprehensive assessment within 14 days of that determination.

6. Quarterly Assessment and Optional Progress Notes—to track resident status between assessments and to ensure monitoring of critical indicators of the gradual onset of significant declines in resident status, a registered nurse:

a. must examine the resident;

b. review the MDS core elements as outlined in the HSS Form Quarterly RA Review:

i. Section B—Items 2 and 4;

ii. Section C—Items 4 and 5;

iii. Section E—Items 1 b-f and 3A;

iv. Section F—Item 1;

v. Section J—Note only disease diagnosis in last 90 days;

vi. Section L—Item 2C;

vii. Section O—Item 4;

viii. Section P—Item 3;

7. Triggers—Level of measurement (coding categories) of MDS elements that identify residents who require evaluation using the care area assessment (CAA) process.

G. Care Area Assessment (CAA) Process and Care Planning

1. CAAs are triggered responses to items coded on the MDS specific to a resident's possible problems, needs or strengths.

2. The CAA process provides:

a. a framework for guiding the review of triggered areas;

b. clarification of a resident's functional status and related causes of impairments; and

c. a basis for additional assessment of potential issues, including related risk factors.

3. The CAA must:

a. be conducted or coordinated by a registered nurse (RN) with the appropriate participation of health professionals;

b. have input that is needed for clinical decision making (e.g., identifying causes and selecting interventions) that is consistent with relevant clinical standards of practice; and

c. address each care area identified under CMS's RAI Version 3.0 Manual, section 4.10, Table 10 (The Twenty Care Areas).

4. CAA documentation should indicate:

a. the basis for decision making;

b. why the finding(s) require(s), or does not require, an intervention; and

c. the rationale(s) for selecting specific interventions.

H. Effective for assessments with assessment reference dates October 1, 2020 and after, the Department of Health mandates the use of the optional state assessment (OSA) item set. The OAS item set is required to be completed in conjunction with each assessment and at each assessment

interval detailed within this Section. The OSA item set must have an assessment reference date that is identical to that of the assessment it was performed in conjunction with.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996), amended by the Department of Health, Bureau of Health Services Financing, LR 46:695 (May 2020).

§10125. Comprehensive Care Plan

A. Basis for the Comprehensive Care Plan. All services in a facility shall be provided in accordance with a physician's written order which shall be developed either before admission or before authorization for payment. The facility must develop a comprehensive care plan for each resident that includes measurable objectives and timetables to meet a resident's medical, nursing, and psychosocial needs that are identified in the comprehensive assessment.

1. The comprehensive assessment shall be developed for residents within 14 days of admission. Written comprehensive care plans shall be developed within seven days of the comprehensive assessment and no later than 21 days of admission. Thereafter, care plans must be updated at least quarterly or when a significant change in the resident's condition occurs.

2. Individual comprehensive care plans shall:

a. be prepared by an interdisciplinary (ID) team that includes the attending physician, a registered nurse with responsibility for the resident, and other appropriate staff in disciplines as determined by the resident's needs;

b. include the resident, resident's family or legal representative, to the extent practicable in the participation of the care planning process;

c. be periodically reviewed and revised by a team of qualified persons after each assessment and/or quarterly review. This requirement is a review for both ICF and SNF. Neurological Rehabilitative Treatment Program (NRTP) levels of care shall be reviewed every 30 days;

d. be located in the medical record and accessible for use by all licensed nursing personnel and any staff directly involved in the integrated care;

e. serve as the primary communication tool among disciplines to ensure that services are coordinated and that the approaches of the various disciplines are integrated;

f. be written in a language understandable to all staff directly involved in the resident's care and the resident in so far as possible; and

g. document that all services ordered are being rendered and properly recorded.

3. Documentation of quarterly staffing must be on the MDS quarterly Review Form as a comparable computerized document. The documentation shall indicate the date of the staffing and who was in attendance.

B. Contents of the Comprehensive Plan of Care

1. The plan of care shall include the following information:

a. identification of all problems and needs according to the resident assessment protocol document as well as any other identified problems;

b. the goals to be accomplished by the resident. These goals shall be:

i. specific;

ii. reasonable; and

iii. measurable;

c. the specific goals regarding discharge. The discharge plans shall:

i. reflect exploration of likely discharge possibilities;

ii. ensure that residents have planned programs of post discharge continuing care which take their needs into account to the extent practicable;

iii. be developed and reviewed in accordance with the facility's written discharge planning procedures;

d. the expected resolution or review date specified for each problem or need;

e. the prescribed integrated, resident specific therapies and treatments designed to help residents achieve their goals;

f. individual or professional services staff responsible for each service prescribed in the plan;

g. all participating staff shall be identified by name and title, when signing the plan of care;

h. all participating staff and the resident, whenever possible, sign and date the following:

i. the initial plan of care; and

ii. each subsequent review. If the resident refuses to sign the plan of care, this fact should be documented for the medical record;

i. physician orders for diet;

j. the daily and weekly time frames for each service included in the plan for residents receiving either complex care or rehabilitation under NRTP (Neurological Rehabilitation Treatment Program).

C. Discharge Summary. When a facility anticipates a discharge, a resident must have a discharge summary that includes:

1. a recapitulation of the resident's stay;

2. a final summary of the resident's status to include medical history, current diagnosis/condition, medical status measurements, functional status, cognitive status, any impairments, nutritional status/requirements, drug therapy,

special treatment, procedures, psychosocial status and rehabilitation potential;

3. must be legible and available for release to authorized persons and agencies with the consent of the resident and/or legal representative; and

4. must be developed with the participation of the resident and his/her family, which will assist the resident in adjusting to a new living environment to the extent practicable.

D. Physician Involvement and Responsibilities in the Comprehensive Plan of Care. A physician is responsible for approving each resident's initial integrated plan of care and each subsequent revision.

1. The physician's approval shall be documented in one of the following places:

a. the plan of care;

b. the order sheet;

c. the progress notes.

2. The documentation referred to above shall be signed and fully dated. The physician may use initials to document review of the plan only if an original legend sheet with a full signature and the initials which will be used is placed on each record.

3. The physician shall review the comprehensive care plan at 90 day intervals.

E. Quarterly Assessment and Optional Progress Notes. The nursing facility must examine each resident no less than once every three months (quarterly) and, as appropriate, to revise the resident's assessment to assure the continued accuracy of the assessment.

1. The quarterly assessments are recorded on the minimum data set quarterly assessment form and may be supplemented by progress notes which reflect the on-going condition and needs of the residents. The quarterly assessments replace all other monthly summaries.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10127. Pharmacy Services

A. The facility must arrange for the provision of pharmaceutical services including procedures that assure the accurate acquiring, receiving, dispensing, and administering of all drugs and biologicals to meet the needs of each resident. Prescription drugs not covered by Medicaid or Medicare shall be at the expense of the resident. However, every attempt should be made to get the attending physician to order a covered medication before the resident incurs any expense.

1. The facility shall provide routine and emergency drugs and biologicals to its residents, or obtain them under an agreement with an outside resource.

2. The arrangement/agreement with an outside resource shall specify in writing that the facility assumes responsibility for:

a. obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and

b. the timeliness of the service.

B. Pharmacist or Pharmaceutical Consultant. Facilities shall employ or obtain the services of a licensed pharmacist. The Pharmacist/Consultant shall be expected to:

1. provide consultation (at least 1 hour per quarter) on all aspects of the provision of pharmacy services in the facility to insure compliance with all state and federal regulations pertaining to Pharmacy Practice;

2. establish a system of recording the receipt and disposition of all controlled drugs in sufficient detail to enable an accurate reconciliation;

3. determine that drug records are in order and that an account of all controlled drugs is maintained and monthly reconciled;

4. perform drug monitoring;

5. identify drug errors;

6. alert the facility to drug recalls; and

7. be aware of adverse reactions/allergic reactions;

a. every 30 days the staff pharmacist or pharmaceutical consultant in nursing facilities shall conduct drug regimen reviews. Additionally, (s)he shall ensure compliance with drug record requirements and compliance with accounting requirements for controlled drugs;

b. the staff pharmacist or pharmaceutical consultant shall notify the attending physician if changes are appropriate;

c. the pharmacist shall report all irregularities to the attending physician or the Director of Nursing or both and these reports must be acted upon. The physician or director of nursing must verify that the irregularity has been noted, even if no changes are made, by initialing and dating;

d. the facility shall maintain a pharmaceutical committee which develops written policies and procedures for safe and effective drug therapy, distribution, control and use;

e. Pharmaceutical Committee:

i. the committee shall be composed of at least the pharmacist, director of nursing, the administrator and one physician;

ii. the committee oversees the pharmaceutical services in the facility, makes recommendations for improvement and monitors the services to ensure accuracy and adequacy;

iii. the committee meets at least quarterly and documents its activities, findings, and the adequacy of the drug program at the nursing facility;

iv. when medications are recorded or placed in unidose by pharmacist, expiration dates shall comply with pharmaceutically accepted practices;

v. the pharmaceutical committee and the facility assessment and assurance committee may be the same committee as long as all requirements are met.

C. Drug Therapy. The facility must ensure that:

1. for each drug ordered for residents there shall be a diagnosis or condition to validate the use of the drug;

2. residents shall not receive antipsychotic drugs unless the drug therapy is necessary to treat a specific condition;

3. residents who receive antipsychotic drugs should receive gradual dose reductions or behavioral programming unless clinically contraindicated in an effort to discontinue these drugs;

4. the facility shall be free of significant medication error rates; and

5. residents shall be free of any significant medication errors.

D. Approved Drugs and Biologicals. Only approved drugs and biologicals are used.

1. Such drugs and biologicals are:

a. included or approved for inclusion in the United States Pharmacopeia, National Formulary, or United States Homeopathic Pharmacopeia; or

b. included or approved for inclusion in AMA Drug Evaluations or Accepted Dental Therapeutics, except for any drugs and biologicals unfavorably evaluated therein; or

c. not included nor approved for inclusion in the compendia listed in the above paragraphs but may be considered approved if such drugs:

i. were furnished to the resident during his prior hospitalization, and

ii. Were approved for the use during a prior hospitalization by the hospital's pharmacy and drug therapeutics committee (or equivalent), and

iii. Are required for the continuing treatment of the resident in the facility.

E. Labeling of Drugs and Biologicals. The labeling of drugs and biologicals is based on currently accepted professional principles and includes the resident's full name, physician's name, full name of pharmacist dispensing, prescription number, name and strength of drug, date of issue, expiration date of all time-dated drugs, name, address, and telephone number of pharmacy issuing the drug, appropriate accessory and cautionary instructions. Non-legend or over-the-counter drugs may be labeled by the facility with resident's full name and room number not to obscure lot number and expiration date.

1. Medication containers which have soiled, damaged, incomplete, illegible, or makeshift labels are to be returned to the issuing pharmacist or pharmacy for relabeling or disposal. Containers which have no labels are to be destroyed in accordance with State and Federal laws.

2. An approved emergency medication kit shall be readily available and have a permit issued by the State Pharmacy Board. Facility must have definition of bonafide emergency in its policies and procedures.

3. The medications of each resident are to be kept and stored in their originally received containers. Transferring between containers is forbidden except by registered pharmacists.

4. A narcotic record shall be maintained which lists on separate sheets for each type and strength of narcotic the following information:

a. date;

b. time administered;

c. name of resident;

d. dose;

e. physician's name;

f. signature of person administering dose; and

g. balance (i.e. Barbiturates, non-narcotic analgesics and hypnotic).

5. Poisons and medications for "external use only" shall be kept in locked area separate from internal medications.

6. Medications no longer in use are to be disposed of or destroyed in accordance with Federal and State laws and regulations.

7. Expired medications shall be removed from usage and properly disposed of.

F. Storage of Drugs and Biologicals. Drugs and biologicals shall be stored in accordance with State and Federal laws. Drugs and biologicals must be stored in locked compartments and under proper temperature controls. Only authorized personnel shall be permitted access to the keys.

1. Separately locked, permanently affixed compartments for storage of controlled drugs listed in Schedule II of the Comprehensive Drug Abuse Prevention and Control Act of 1970 shall be provided.

2. Other drugs subject to abuse must be secure except when a single unit package drug distribution system is used in which the quantity stored is minimal and a missing dose can be readily detected.

H. Ordering of Medications. The facility shall neither expect, accept, nor require any provider to give a discount or rebate for prescription services rendered by pharmacists.

1. The facility may order at least a one-month supply of medications from a pharmacy of the resident's choice unless the attending physician specifies that a smaller quantity is necessary for a special medical reason. If a one-month supply is less than 100 unit doses, then 100 unit doses may be ordered.

2. The facility administrator or the authorized representative shall certify receipt of prescribed medications by signing and dating the pharmacy bill.

I. Unnecessary Drugs

1. Each resident's drug regimen is free of unnecessary drugs. For each drug ordered for residents there must be a diagnosis or condition to validate the use of the drug.

2. Residents shall not receive antipsychotic drugs unless the drug therapy is necessary to treat a specific condition. There shall be documentation in the chart that the resident is being monitored for side effects.

3. Residents who receive antipsychotic drugs should receive gradual dose reductions or behavioral programming unless clinically contraindicated in an effort to discontinue these drugs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10129. Dietetic Services

A. A designated full-time staff member suited by training and experience in food management and nutrition shall be responsible for supervision of dietary services. If the designated staff member is not a qualified dietitian, he/she shall serve as the dietary manager and shall function with frequent, regularly scheduled consultation from a person who is a qualified dietitian. A minimum consultation time shall be not less than eight hours per month and as needed to ensure nutrition needs of residents are addressed timely. A copy of the consultant's contract shall be available to the State Survey Agency for review. In addition, the facility shall employ sufficient supportive personnel competent to carry out the functions of the dietetic service. Food service personnel shall be on duty daily for a period of 12 or more continuous hours.

B. Dietitian

1. The facility shall employ a qualified dietician either full-time, part-time or on a consultant basis.

2. If a qualified dietician is not employed full time, the facility shall designate a person to serve as the dietary manager.

3. A qualified dietician is one who is qualified based upon registration by the Commission on Dietetics of the American Dietetic Association and licensure by the Louisiana Board of Examiners in Dietetics and Nutrition.

C. Dietary Manager. (S)he is a person who is one of the following:

1. a qualified dietitian;

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

3. has successfully completed a course of study, by correspondence or otherwise, which meets the minimum eligibility requirements for membership in the Dietary Managers' Association

4. has successfully completed a training course at a state approved school, vocational or university, which includes course work in foods and food service, supervision, and diet therapy. Documentation of an eight hour course of formalized instruction by the employing facility's consultant dietitian in therapeutic diets is permissible if the course of study meets on the foods and food service and supervision requirements or

5. is currently enrolled in an acceptable course which will qualify an individual upon completion.

D. Dietary Consultant

1. If the staff members designated as food service supervisors are not qualified dieticians, they shall be required to schedule a minimum of eight hours of consultation per month with qualified dieticians.

2. The facility must employ sufficient support personnel competent to carry out the functions of the dietary service.

E. Menus. Menus must:

1. meet the nutritional needs of the residents in accordance with the recommended dietary allowance of the Food and Nutrition Board of the National Research Council, National Academy of Sciences;

2. be prepared in advance; and

3. be followed.

4. Menu changes are acceptable provided the above requirements are met. Records of menus as actually served are retained for six months.

F. Food. Food must be:

1. prepared by methods that conserve nutritive value, flavor and appearance;

2. palatable, attractive and at the proper temperature;

3. prepared in a form designed to meet individual needs; and

4. substituted for residents who refuse food served and the substitutes offered shall be of similar nutritional value.

5. Therapeutic diets must be prescribed by the attending physician.

G. Frequency of Meals. At least three meals shall be served daily at regular times comparable to normal mealtimes of the community.

1. There must be no more than 14 hours between a substantial evening meal and breakfast the following morning except as provided below:

a. bedtime snacks must be offered each evening; and

b. when a nourishing snack is provided at bedtime up to 16 hours may elapse between a substantial evening meal and breakfast the following day if a resident group agrees to this meal span.

H. Assistive Devices. The facility must provide special eating equipment and utensils for residents who need them.

I. Sanitary Conditions. The facility must:

1. procure food from sources approved or considered satisfactory by federal, state, or local authorities;

2. store, prepare, distribute, and serve food under sanitary conditions; and

3. dispose of garbage and refuse properly.

J. Diets. If the facility accepts or retains individuals in need of medically prescribed special diets, the menus for such diets are to be prescribed by the attending physician and planned by a professionally qualified dietitian. A current therapeutic diet manual approved by the dietitian shall be readily available to attending physicians, nursing staff, and dietetic service personnel.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10131. Social Services

A. A NF with more than 120 beds must employ a full-time qualified social service director with the following qualifications:

1. a bachelor's degree in social work or a bachelor's degree in a human services field including but not limited to sociology, special education, rehabilitation counseling, and psychology; and

2. one year of supervised social work experience in a health care setting working directly with individuals; or

3. a similar professional degree in a field such as counseling, special education, sociology, or psychology.

B. A NF with 120 beds or less shall designate at least one staff member as social service designee (SSD). The SSD need not have any special educational background.

1. The individual responsible for provision of social services shall:

a. arrange for social services from outside sources or by furnishing the services directly;

b. integrate social services with other elements of the plan or care; and

c. complete a social history.

C. Social History. The SSD shall complete, date, and sign a social history on applicants/residents within seven days after their admission. The history shall include but shall not be limited to the following information:

1. background:

a. age, sex, and marital status;

b. birthplace;

c. religion;

d. cultural and ethnic background;

e. occupation;

f. education;

g. special training or skills; and

h. primary language;

2. social functioning:

a. living situation and address before admission;

b. names and relationships with family and friends;

c. involvements with organizations and individuals within the community;

d. feelings about placement in the nursing facility.

C. Social Needs Assessment

1. The SSD shall also identify and document the needs and medically related social/emotional problems within 14 days after admission.

2. The social services assessment shall become a component of the plan of care written in conjunction with other disciplines and shall be filed in the active medical record.

3. If the initial social assessment concludes that there are no problems or unmet social needs, the social assessment shall state that no social services are required.

D. Participation in Interdisciplinary Staffing. The SSD shall participate in the interdisciplinary staffing.

E. Social Services Progress Notes. Social services progress notes shall:

1. be recorded as often as necessary to document services provided, but at least every 90 days (quarterly) in NF's and as often as necessary to describe changes in social conditions;

2. document the degree of involvement of family and friends, interaction with staff and other residents, and adjustment to the facility and roommate(s);

3. reflect the social needs and functioning;

4. document services in the plan of care are actually being provided; and

5. remain in the active medical chart for three to six months.

NOTE: The facility shall establish policies and procedures for ensuring the confidentiality of all social information. Records shall reflect each referral to an outside agency and shall include the applicant/resident's written consent to release the information.

NOTE: The Same Qualifications Apply to Medicare Skilled Nursing Facilities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10133. Activity Services

A. The facility shall provide an ongoing activities program designed to stimulate and promote the physical, social, emotional, and intellectual well-being of each resident and encourage normal activity and return to self care.

B. Resident Activity Director. The facility's activities program shall be under the direction of the resident activity director (RAD).

1. The nursing facility shall have at least one RAD. An additional RAD per resident census in excess of 100 shall be required. The RAD employees shall be full-time or sufficient full-time equivalent employees shall be maintained to comply with these standards. Regardless of the number of RAD employees required, one full-time RAD shall be certified.

2. Responsibilities of the RAD include the following tasks:

a. scheduling and coordinating group activities and special events inside and outside the facility;

b. developing and using outside resources and actively recruiting volunteers to enhance and broaden the scope of the activities program;

c. posting monthly activity calendars in places where applicants/residents and staff can easily see them;

d. planning and implementing individual and group activities designed to meet the applicants/residents' needs and interests.

3. A resident activity director may be one of the following individuals:

a. a qualified therapeutic recreation specialist:

i. who is certified with the National Council on Therapeutic Recreation Certification; and

ii. eligible for certification as therapeutic recreation specialist by a recognized accrediting body on August 1, 1989;

b. a person having the following experience:

i. two years of experience in a social or recreational program within the last five years;

ii. one year of the experience shall have been gained as a full-time employee in a health care setting involving resident activities programs;

c. a qualified occupational therapist or occupational therapy assistant;

d. An individual who has completed a training course approved by the Department.

e. An individual who is enrolled in a training course approved by the department.

NOTE: Prior to the effective date of this document the Resident Activity Director (RAD) was referred to as Patient Activities Coordinator (PAC) or Patient Activity Director (PAD).

C. Activities Assessments

1. Within 14 days after admission, the RAD shall complete a written assessment of each resident's interests and hobbies and note any illnesses or physical handicaps which might affect participation in activities.

2. The activities assessment shall:

a. become the basis for the activities component of the plan of care;

b. be signed, dated, and filed with other elements in the medical record;

c. identify specific problem/need areas along with specific approaches formulated to meet the problems/needs; and

d. be included in the interdisciplinary staffing.

C. Activity Services Progress Notes. Activity services progress notes shall:

1. be written to document the services provided and/or changes in activity needs or approaches at least every 90 days (quarterly); and

2. document the activity level of residents, specifically describing their day to day activities.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10135. Medical Records

A. The facility shall maintain medical records which include clinical, medical, and psychosocial information on each resident.

1. These records must be:

a. complete;

b. accurately documented;

c. readily accessible; and

d. systematically organized.

2. Facilities shall have written policies and procedures governing access to, duplication of, and dissemination of information from the resident's personal and medical records.

B. Availability of Records

1. The facility shall make necessary records available to appropriate state and federal personnel at reasonable times. Records shall include but shall not be limited to the following:

a. personal property and financial records; and

b. all medical records

NOTE: This includes records of all treatments, drugs, and services for which vendor payments have been made, or which are to be made, under the Medical Assistance Program. This includes the authority for and the date of administration of such treatment, drugs, or services. The facility shall provide sufficient documentation to enable DHH to verify that each charge is due and proper prior to payment.

c. All other records which DHH finds necessary to determine a facility's compliance with any federal or state law, rule, or regulation promulgated by the Department of Health and Human Services (DHHS) or by DHH.

2. Overall supervisory responsibility for the resident record service is assigned to a responsible employee of the facility. If the resident record supervisor is not a qualified medical record practitioner, this person functions with consultation from a person so qualified minimum consultation time shall not be less than one hour per quarter.

C. Availability of Medical Records to Facility Staff. The facility shall ensure that medical records are available to licensed staff directly involved with the resident's care.

D. Confidentiality. Facilities shall ensure confidential treatment of personal and medical records, including information contained in automatic data banks. The written consent of the resident or his/her legal representative shall be required for the release of information to any persons not otherwise authorized under law to receive it.

E. Protection of Records. The facility shall protect records against loss, damage, destruction, and unauthorized use.

F. Retention of Records. The facility shall retain records for:

1. in the case of minors, three years after they become 18 years of age; and

2. six years after the date of discharge.

G. Components of Medical Records. Each medical record shall consist of the active medical chart and the facility medical files or folders.

1. Active Medical Charts

a. The active medical charts shall contain the following information:

i. three to six months of current pertinent information relating to the active ongoing medical care;

ii. physician certification of each medical assistance admission;

iii. physician recertification that the resident required the services of the facility;

iv. certification that each plan of care has been periodically reviewed and revised; and

v. if the facility is aware that an resident has been interdicted, a statement to this effect shall be noted in a conspicuous place in the active medical chart.

2. Medical Files. As the active chart becomes bulky, the outdated information shall be removed and filed in the facility's medical files or folders.

H. Contents of Medical Records. An organized active record system shall be maintained for each resident. It shall include the following identifying information:

1. full name;

2. home address, including street address, city, parish, and state;

3. social security number;

4. medical identification number;

5. medicare claim number, if applicable;

6. marital status;

7. date of birth;

8. sex;

9. religious preference;

10. birthplace;

11. father's name;

12. mother's maiden name;

13. name, address, and telephone number of referral agency or hospital;

14. personal attending physician and alternate, if possible;

15. choices of other service providers;

16. name and address of next of kin or other legal representative or sponsor;

17. admitting diagnosis;

18. current diagnosis, including primary and secondary DSM III diagnosis, if applicable;

19. date of death;

20. cause of death;

21. diagnosis at death;

22. copy of death certificate;

23. disposition of body;

24. name of funeral home, if appropriate; and

25. any other useful identifying information.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10137. Ancillary Services.

A. Dental Services

1. The facility shall assist residents in obtaining routine and 24 hour emergency dental care to meet needs of each resident.

2. Routine dental services are defined as including dentures, relines and repairs to dentures, and some oral surgeries. Medicaid residents may be charged for dental services which are not covered services, i.e., extraction, fillings, etc. For residents who are unable to pay for needed dental services, the facility should attempt to find alternative funding sources or alternative service delivery systems.

3. The facility shall, if necessary, assist the resident in making appointments and arranging for transportation to and from the dentist office.

4. The facility is responsible for promptly referring residents with lost or damaged dentures to a dentist who participates in the Medicaid Program.

5. The Medicaid participating dentist should be contacted to give specific information as to what dental services are Medicaid-covered services, when prior approval is necessary, and what dental procedures are not reimbursable by Medicaid.

B. Radiology and Other Diagnostic Services

1. The facility shall arrange for the provision of radiology and other diagnostic services to meet the needs of its residents. The facility is responsible for the quality and timeliness of the services and shall:

a. arrange for the provisions of radiology and other diagnostic services only when ordered by the attending physician;

b. promptly notify the attending physician of the findings;

c. assist resident in making transportation arrangements to and from the source of service as needed;

d. file in the resident's clinical record signed and dated reports of X-ray and other diagnostic services.

2. If the facility provides its own diagnostic services, the services shall meet the applicable conditions of participation of hospitals contained in 42 CFR 482.26.

3. If the facility does not provide diagnostic services, it shall have an agreement to obtain these services from a provider or supplier that is approved to provide these services under the Medicare/Medicaid Program.

C. Laboratory Services.

1. The facility must arrange for the provision of clinical laboratory services to meet the needs of the residents. The facility is responsible for the quality and timeliness of the services and shall:

a. provide or obtain laboratory services only when ordered by the attending physicians;

b. promptly notify the attending physician of the findings; and

c. Assist resident in making transportation arrangements to and from the services as needed.

2. A facility performing any laboratory service or test must have appealed to HCFA or received a certificate of waiver or a certificate of registration.

3. An application for a certificate of waiver may be needed if the facility performs only the following tasks on the waiver list:

a. dipstick or table reagent urinalysis;

b. fecal occult blood;

c. erythrocyte sedimentation rate;

d. hemoglobin;

e. blood glucose by glucose monitoring

f. devices cleared by FOA specifically for home use;

g. spun micro hematocrit;

h. ovulation test; and

i. pregnancy test.

4. Appropriate staff shall file in the residents' clinical record signed and dated reports of clinical laboratory services.

5. If the facility provides its own laboratory services, the services shall meet the applicable conditions for coverage of services furnished by independent laboratories.

6. If the facility provides blood bank and transfusion services it shall meet the applicable conditions for independent laboratories and hospital laboratories and hospital laboratories at 42 CFR 482.27.

7. If the facility laboratory chooses to refer specimens for testing to another laboratory, the referral laboratory shall be approved for participation in the Medicare Program either as a hospital or an independent laboratory.

8. If the facility does not provide laboratory services on site, it shall have an agreement to obtain these services from a laboratory that is approved for participation in the Medicare Program either as a hospital or as an independent laboratory.

D. Specialized Rehabilitative Services

1. A facility must provide or obtain rehabilitation services such as physical therapy, occupational therapy, and speech therapy to every resident when the physician deems it necessary.

2. Specialized rehabilitative services are considered a facility service and are, thus, included within the scope of facility services. They must be provided to residents who need them even when the services are not specifically enumerated in the State Plan. No fee can be charged a Medicaid resident for specialized rehabilitative services because they are covered facility services.

3. If specialized rehabilitation services are required in the resident's comprehensive plan of care, the facility shall:

a. provide the services;

b. obtain the required services from an outside resource through contractual arrangement with a person or agency who is qualified to furnish the required services.

4. Arrangements or agreements pertaining to services furnished by outside resources shall specify in writing that the facility assumes responsibility for:

a. obtaining services that meet professional standards and principles that apply to professionals providing services in such a facility; and

b. the timeliness of the service.

5. Specialized rehabilitation services shall be provided under the written order of a physician by qualified personnel.

E. Non-Emergency Transportation for Medical Appointments

1. It is the responsibility of the nursing facility to arrange for or provide transportation to all necessary medical appointments. This includes wheelchair bound residents and those residents going to therapies and hemodialysis. Transportation shall be provided to the nearest available qualified provider of routine or specialty care within reasonable proximity to the facility. Residents can be encouraged to utilize medical providers of their choice in the community in which the facility is located when they are in need of transportation services. It is also acceptable if the facility or legal representative/sponsor chooses to transport the resident. In cases where residents are bedbound and cannot be transported other than by stretcher and the nursing facility is unable to provide, an ambulance may be used. The ambulance provider will be reimbursed at the non-emergency transportation rate.

F. Attendants During Travel. The facility is required when medically appropriate, to provide an attendant if the resident or the responsible party cannot arrange for an attendant. Under no circumstances shall the facility require the resident or responsible party to pay for an attendant. However, if a resident is being admitted to a hospital and transportation is via ambulance, then an attendant is not necessary.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10139. Hospice Services.

A. Effective July 1, 1993, a Louisiana nursing facility (NF) resident who is eligible for both Medicare and Medicaid can elect the Medicare hospice benefit if the nursing facility is being or will be reimbursed for the resident's care by Medicaid.

B. Hospice care focuses on assuring the quality of the terminal resident's remaining life rather than on trying to prolong the length of that life. It is a program of palliative (control of pain and symptoms) and supportive services which provides physical, psychological, social and spiritual care for dying persons and families.

C. Hospice Admission Criteria

1. Resident is enrolled in Medicare Part A and is Medicaid eligible or in applicant status.

2. A prognosis of six months or less confirmed by the attending physician. The prognosis of the terminal illness must be in terms of days, weeks, or months.

3. Election of the hospice benefit must be made by the competent resident or family member in the order described by Louisiana law for the non-competent resident.

4. Care goal must be palliative and not curative.

5. Resident shall be under the care of an attending physician who consents to the Hospice admission and who will continue to assume responsibility for medical care.

6. The resident lives in a nursing facility within the Hospice service area.

7. Final determination of medical eligibility for admission to hospice is made by the Health Standards Section of the Bureau of Health Services Financing.

D. Provider Responsibilities. The nursing facility and the hospice shall have a contractual agreement outlining the specific responsibilities of each entity which shall include but is not limited to:

1. eligible residents;

2. services to be furnished by the Hospice;

3. services to be furnished by the nursing facility;

4. cooperation in professional management;

5. financial responsibility;

6. provider of first choice;

7. public relations;

8. compliance with government regulations;

9. terms of agreement; and

10. indemnification and limit of liability.

E. This agreement shall commence as of the date appearing and continue until terminated by either party by giving 30 days written notice to the other party. This agreement may be amended by mutual agreement of the NF and Hospice.

F. The NF and Hospice shall continue to meet all federal regulations for certification and state requirements for licensure.

G. The resident who is receiving Hospice in the NF will be subject to surveys for both the Long Term Care and Hospice programs.

H. Medicaid Reimbursement. When a dually eligible resident elects the Medicare hospice benefit and the hospice and the nursing facility have a written agreement under which the hospice is responsible for the professional management of the resident's hospice care and the NF agrees to provide room and board to the resident, the Medical Assistance Program will pay the hospice an amount equal to the per diem for NF care. Medicaid payment to the NF is discontinued when payment to the hospice begins. Discharge and admission forms (Form 148) are filed by the NF and the hospice provider effecting the transfer.

1. With respect to the management of a resident's terminal illness, the NF shall:

a. notify Hospice of changes in the resident's condition; and

b. make records of care and services to the resident available to Hospice.

2. The NF may continue to collect the resident's personal liability income (PLI) to be applied to the Medicaid per diem.

I. Admission Review. The following procedures shall be followed when the Hospice benefit is elected by the dually eligible resident currently residing in the NF:

1. The NF shall:

a. discontinue billing Medicaid on the date the hospice is elected and an agreement between NF and Hospice is signed and effectuated;

b. notify the Health Standards Regional Office and respective parish office by Form 148 that the resident is being placed in the Hospice category on effective date; and

c. provide the hospice provider a copy of Form 148 indicating the date of transfer to Hospice.

2. The Hospice is responsible for submitting the following information to the Health Standards Regional Office for review:

a. the attending physician's referral confirming prognosis of less than six months and to approve the hospice admission;

b. the hospice RN assessment;

c. the plan of care;

d. Form 148 to indicate the effective date of admission to hospice care, and a copy of Form 148 from the NF indicating the date of transfer for those residents who are already placed in a NF.

3. The following procedures shall be followed when the Hospice benefit is elected by an individual prior to admission to the NF:

a. The NF shall submit Form 148, 90-L, and PASARR-1 to the Health Standards Regional Office for review.

NOTE: Form 148 will specify the level of care, effective date of admission and add the notation at the bottom of the admission section that the resident is entering the hospice at the same time. Representatives of both the NF and the Hospice should sign Form 148 at the bottom.

b. The Hospice shall submit the following information to the Health Standards Regional Office for review:

i. the attending physician's referral confirming prognosis of less than six months and to approve the hospice admission;

ii. the hospice RN assessment

iii. the plan of care.

J. Provider of First Choice. The NF retains the right to decide if it wishes to offer the option of Hospice. If Hospice is offered, the NF agrees to exert its best efforts to promote the use of Hospice home care services by directing the personnel of the NF to refer all terminally ill residents, subject to the informed consent of the resident and the approval of the attending physician, to the Hospice. If the NF chooses not to offer Hospice and a resident wishes to receive the services, the resident shall be informed that Hospice is not available in the NF and assist with arrangements for transfer to another facility that offers the service if they so choose.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10141. Mental Health Rehabilitation Services

A. Mental health rehabilitation services are defined as medically necessary services which can reasonable be expected to reduce the resident's disability resulting from mental illness and to restore the individual to his/her best possible functional level in the community. The services are provided outside of a mental institution (or distinct part psychiatric unit) on an as needed basis to assist residents in coping with the symptoms of their illnesses, minimizing the disabling effects of mental illness on their capacity for independent living, and preventing or limiting periods of in-resident treatment. These services are an optional Medicaid service authorized under section 440.130(d) of the Code of Federal Regulations. Residents in nursing facilities shall have been identified as needing these services through the

pre-admission screening and annual resident review process (PASARR).

B. Mental health rehabilitation services must be ordered by a physician and provided by or under the supervision of a qualified mental health professional according to a rehabilitation care plan which includes the comprehensive mix of services recommended by the physician and the QMHP.

C. Mental health rehabilitation services consist of the planning, delivery, and management of mental health therapeutic services. These services differ from those provided under the Medicaid Clinic Option by the location(s) in which they are provided. Mental health rehabilitation services are not restricted to a community mental health clinic or an in-resident setting. They may be provided in community settings or in any facility which does not provide mental health services as part of its program. They differ from case management services for the chronically mentally ill which involve arranging access to and coordinating a wide range of services of which mental health rehabilitation is only a party.

D. Mental Health Definitions

1. Specialized Services for Mental Illness. Specialized services for the treatment of mental illness are those services for people with mental illness whose needs are such that continuous supervision, treatment, and training by qualified mental health personnel (QMHP's) is necessary, and/or for persons who are experiencing an acute episode of serious mental illness. These services are beyond the scope of services provided by the nursing facility, and require high degree of intensity. These services, combined with the services provided by the nursing facility, result in the continuous and aggressive implementation of a plan of care.

2. The following are specialized services as described above:

a. Mental Health Rehabilitation Management—Services provided according to a care plan developed by a licensed professional who is a QMHP, in conjunction with a physician.

b. Psychiatric, psychosocial, psychological and other evaluations or assessments—Discipline: Specific information gathered and integrated for diagnosis, establishment of specific treatment goals, analysis of programs, and/or updating the care plan and goals, evaluating and ordering medications. This may include development and implementation of a behavior program on an intensive basis.

c. Individual, group, and/or family therapy—Face-to-face structured, time-limited, and verbal interactions between counselors or therapists and person(s) receiving the service.

d. Psychosocial skills training—Services specified in the individual's plan of care to be provided by a QMHP or paraprofessionals under the supervision of a QMHP, with focus on the remediation of mental and functional disabilities through skills training and/or supportive interventions.

e. Training in ADL's—Activities which enhance or develop the resident's basic daily living skills.

f. In-resident psychiatric services—Highly restricted, intensive and supervised services in a hospital setting reserved for extreme situations for individuals exhibiting an exacerbation of an acute disturbance or difficult ongoing problems.

3. Medication management is not a billable service for a nursing facility resident.

E. Services of a Lesser Intensity for Mental Illness. Services may be provided at a lesser intensity and frequency and level of aggressiveness for the treatment of mentally ill persons who are in need of some types of services for their condition. These services are within the scope of services which are provided or arranged by the nursing facility. They are intended to help nursing facility residents with a diagnosis of mental illness to achieve the highest possible level of mental and psychosocial well being.

1. The following are examples of services of a lesser intensity:

a. medical management, including medication management (provided by the nursing facility), as specified in the resident's plan of care: Services designed for the individual, taking into account the resident's total needs and problems, including prescribing, administering, and monitoring all medications;

b. counseling regarding adjustment to the nursing facility, interpersonal relations, and family involvement (provided by the nursing facility): Short term counseling designed to assist the resident in his adjustment to the facility;

c. training and support to maintain functional level (provided by the nursing facility) as specified in the resident's plan of care: Activities tailored to the individual's physical, emotional, and social needs, including ADL's, independent living skills, and communication skills, which may include coordination with primary therapist(s), follow through, and support of a behavior program;

d. social services support (provided by the nursing facility): Activities and/or services tailored to the individual's social needs, in consideration of the total medical needs such as transportation, referrals to other agencies or community programs, or assistance in obtaining medical appliances and devices;

e. age and functional level activity program (provided by the nursing facility) as specified in the resident's plan of care: Activities designed individually to address the needs of the resident, such as structured work and leisure activities.

F. Mental Health Rehabilitation Option in Nursing Facilities. Criteria for participation in program:

1. resident shall be an adult with chronic mental illness. The program is not for persons who are newly diagnosed with a mental illness;

2. the attending physician shall order the assessment and sign off on the plan of care when developed by the agency which will be providing services;

a. documentation to be maintained by the facility:

i. the rehabilitation agency will obtain consent from the resident to gain access to information in the facility medical record;

ii. a BCSW will do a psychosocial evaluation in order to develop a plan of care;

iii. the plan of care will be developed and incorporated into the medical record. This process should include the resident, residents legal representative or sponsor, and facility staff;

iv. the plan of care should be updated every 90 days;

v. there should be documentation of symptoms and progress or lack of progress toward goals.

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Subchapter E. Reserved

Subchapter F. Vendor Payments

§10147. General Provisions

A. Residents Receiving Care Under Title XIX (Medicaid) Only

1. The BHSF Medicaid Program shall determine the resident's applicable income (liability when computing facility vendor payments. Vendor payments are subject to the following conditions.

a. Vendor payments shall begin with the first day the resident is determined categorically and medically eligible or the date of admission, if later.

b. Vendor payments shall be made as determined by the facility per diem rate less the resident's per diem applicable income for the number of eligible days.

c. If a resident transfers from one facility to another, the vendor payments to each facility is the facility's per diem rate for the number of days in the facility, less the resident's per diem applicable income for the total number of days in each facility.

2. Retroactive Payment. When individuals enter a facility before their Medicaid eligibility has been established, payment for facility services is made retroactive to the first date of eligibility after admission.

3. Resident Personal Care Income. The facility shall not require that any part of a resident's personal care income be paid as a part of the facility's fee. Personal care income is an amount set aside from a resident's available income to be used for personal needs. The amount is determined by the Department of Health and Hospitals.

a. The facility shall not permit tips for services rendered by facility employees.

B. Residents Receiving Care Under Title XVIII (Medicare). Resident income shall not be considered in determining vendor payments for a period of up to 100 days provided he/she remains eligible for Title XVIII-A (Medicare). This also includes the period for which coinsurance is being paid by the Medicaid Program.

C. Timely Filing For Reimbursements. Vendor payments cannot be made when more than 12 months have elapsed between the month of initial service and submittal of a claim for these services. Payment of claims more than 12 months old require the approval of the Bureau of Health Services Financing Program Operations Section.

D. Temporary Absence of the Resident; No Evacuation. Payment procedures for periods of temporary absnce are subject to the following conditions.

1. The facility keeps a bed available for the resident's return and provides notification in accordance with the Bed Reservation Policy requirements in the chapter entitled *Transfer and Discharge Procedures.*

2. The absence is for one of the following reasons:

a. hospitalization for an acute condition including psychiatric stays, which does not exceed 5 days per hospitalization;

b. home leave.

NOTE: Payment cannot be mad for hospital leave days while a resident is receiving swing bed SNF services.

3. When the hospital has determined that discharge is appropriate for a resident who had been admitted to the hospital from a nursing facility, the nursing facility shall readmit this resident on the date the physician writes the discharge regardless of the hour of the day or the day of the week. This includes holidays and weeks.

4. Payment will not be made to the nursing facility for hospital leave days beyond the date of the physician's date of discharge from the hospital.

5. Home leave (leave of absence), is defined as a visit with relatives or friends which does not exceed 9 days per calendar year. Institutionalization is not broken if the absence does not exceed 14 days and if the facility has not discharged the resident.

NOTE: Elopements (unauthorized absences under the plan of care) count against allowable home leave days.

6. The period of absence shall be determined by counting the first day of absence as the day the resident leaves the facility.

7. Only a period of 24 continuous hours or mroe shall be considered an absence. Likewise, a temporary leave of absence for hospitalization or home visit is broken only if the resident returns to the facility for 24 hours or longer.

8. Upon admission, a resident must remain in the facility at least 24 hours in order for the facility to submit a payment claim for a day of service or reserve a bed.

EXAMPLE: A resident admitted to a nursing facility in the morning and transferred to the hospital that afternoon would not be eligible for any vendor payment for facility services.

9. If a resident transfers from one facility to another, the unused home leave days for that calendar year also transfer. No additional leave days are allocated.

10. The facility shall promptly notify the Parish/Regional BHSF Office of absences beyond the applicable, 14, 5, or 4 day limitations.

E. Temporary Absence Due To Evacuation. When local conditions require evacuation of residents in nursing facilities, the following payment procedures apply.

1. When the resident is evacuated for less than twenty four (24) hours, the monthly vendor payment to the facility is not interrupted.

2. When the staff is sent with the resident(s) to the evacuation site, the monthly vendor payment to the facility is not interrupted.

3. When the resident is evacuated to family or friend's home, at the facility's request, the facility shall not submit a claim for a day of service or leave day, and patient liability shall not be collected.

4. When the resident goes home at the family's request or on their own initiative, a leave day shall be charged.

5. When the resident is admitted to the hospital for the purpose of evacuation of the nursing facility, Medicaid payment shall not be made for the hospital charges.

F. Resident Deposits. A facility shall neither require nor accept an advance deposit from a resident whose Medicaid eligibility has been established.

EXCEPTION: A facility may require an advance deposit for the current month only on the part of the total payment which is the resident's liability.

1. If advance deposits or payments are required from residents or residents legal representative or sponsor upon admission when Medicaid eligibility has not been established, then such a deposit shall be refunded or credited to the person upon receipt of vendor payment.

2. Credit on the facility's books in lieu of a refund to the resident or resident's legal representative or sponsor is acceptable within the following limitations:

a. Such credit shall not exceed an amount equal to the resident's liability for 60 days following the date the resident was determined eligible for Medicaid.

b. Any deposit exceeding such an amount shall be refunded within five working days to the resident or resident's legal representative or sponsor.

G. Refunds to Bureau of Health Services Financing Medicaid Program

1. A Non-Participating Facility. Vendor payments made for the services performed while a facility is in a non-participating status shall be refunded to the Department of Health and Hospitals, Office of Management and Finance. The refund shall be made payable to the Bureau of Health Services Financing Medicaid Program.

2. A Participating Facility. A currently participating Medicaid facility shall correct billing or payment errors by the use of appropriate Adjustment/Void or Resident Liability (PLI) adjustment form.

H. Refunds to Residents. Advance payments for a resident's liability (applicable income) shall be refunded promptly if he/she leaves the facility before the end of the month. The facility shall adhere to the following procedures for the refunds.

1. The proportionate amount for the remaining days of the month shall be refunded to the resident or the resident's legal representative or sponsor no later than the end of the month following discharge. If the resident has not yet been certified, then the procedures spelled out in Refunds to Residents, paragraph one, shall apply.

2. No penalty shall be charged to the resident or resident's legal representative or sponsor even if the circumstances surrounding the discharge occurred as follows:

a. without prior notice;

b. within the initial month; and

c. within some other "minimum stay" period established by the facility.

3. Proof of refund of the unused portion of the applicable income shall be furnished to the BHSF Medicaid Program upon request.

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HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10149. Services and Supplies

A. Regulations pertaining to this subsection are incorporated under the state plan for the Medicaid program and included in the Medicaid Eligibility Manual (MEM).

B. Services and Supplies Included. The nursing facility shall be responsible for providing the following services, supplies, and equipment to Medicaid residents:

1. room, board, and therapeutic diets; and

2. food supplements or food replacements, including at least one brand of each type (i.e., regular, high fiber, diabetic, high nitrogen).

NOTE: This does not include enteral/parenteral nutrients, accessories and/or supplies.

3. General services as listed below:

a. professional nursing services;

b. an activities program with daily supervision of such activities;

c. medically-related social services; and

d. other services provided by required staff in accordance with the plan of care.

4. Personal Care Need. The facility shall provide personal hygiene items and services when needed by residents to include:

a. hair hygiene supplies;

b. comb;

c. brush;

d. bath soap;

e. disinfecting soaps or specialized cleansing agents when indicated to treat special skin problems or to fight infection;

f. razors;

g. shaving cream;

h. toothbrush;

i. toothpaste;

j. denture adhesive;

k. denture cleaner;

l. dental floss;

m. moisturizing lotion;

n. tissues;

o. cotton balls;

p. cotton swabs;

q. deodorant;

r. incontinence supplies;

s. sanitary napkins and related supplies;

t. towels;

u. washcloths;

v. hospital gowns;

w. hair and nail hygiene services;

x. bathing;

y. basic personal laundry;

z. incontinence care.

NOTE: Special hair cuts, permanent waves, and other such services, which are provided by a licensed barber or beautician at the request of the resident shall be paid directly by residents from their personal funds, or by their legal representative or sponsors, unless provided as a free service by the facility.

5. Drugs

a. Over the counter drugs are part of pharmaceutical services that the nursing facility is responsible for providing when it is specified in the resident's plan of care. If the prescribing physician does not specify a particular brand in the written order, a generic equivalent is acceptable. If the physician specified a particular brand, the nursing facility would have to incur the cost of providing that drug. If the physician does not specify a particular brand, but the resident insists on receiving a particular brand, the nursing facility is not required to provide the requested drug. However, if the facility honors the resident's request, it may, after giving appropriate notice, make a charge to the resident's funds for the difference between the cost of the requested item and the cost of the generic.

b. Presceiption drugs prescribed by the attending physician shall be filled by the Pharmacy. Reimbursement shall be made as follows.

i. The pharmacy shall submit claims to the state Medicaid program for drugs covered under the program.

ii. The resident is financially responsible for prescription drugs not covered under the Medicaid program. The limit of the liability is from the resident's resources. A legal representative or sponsor cannot legally be held personally liable for the resident's debt; such person can only be required to pay the resident's debts from the resident's funds. Prior to charging a resident, for a medication, the prescribing physician should be notified that it is not covered by the Medicaid program and asked if an equivalent alternative that is covered can be prescribed. A resident should not be denied a needed medication simply because of inability to pay.

6. Wheelchairs

a. Standard Wheelchair. Standard wheelchairs shall be provided in adequate numbers to meet the temporary mobility or general transporation needs of residents.

b. Customized Wheelchairs. Customized wheelchairs may be obtained for Medicaid recipients with prior authorization through the DME program of Medicaid. If this is not an option for the resident, the nursing facility shall attempt to arrange for the provision of customized wheelchairs as needed through family, community resources, etc. Customized wheelchairs purchased by the nursing facility shall be allowable in the cost report. Repairs to a wheelchair owned by a resident are not the responsibility of the facility. For residents who are unable to pay for such repairs, the facility shall assist them in finding alternative funding sources.

7. Other. The facility shall also provide an adequate number of the following items:

a. standard, adjustable walkers;

b. crutches;

c. over-bed tables;

d. bedside commodes;

e. lifts;

f. restraints;

g. sheepskins or similar decubitus prevention and treatment devices;

h. mechanical supports such as Posey vest-type;

i. suction machines for general use (DME Program will purchase, with prior approval, suction machines and other related equipment for those residents meeting the DME program need requirements);

j. glucometers and diabetic supplies;

k. blood pressure cuffs;

l. stethoscopes;

m. other such items which are generally a part of nursing facility treatment.

NOTE: A facility is not required to provide clothing except in emergency situations. If provided, it shall be of reasonable fit.

C. Medical Supplies. The facility shall provide the following apparatus:

1. all types of syringes and needles;

2. I-V set-ups;

3. tubing and bags of all kinds except those provided through other funding sources;

4. gauze;

5. bandages;

6. thin film wound dressings (Tegraderm, Duoderm, and similar products); and

7. non-adhering dressings (Telfa or similar products).

D. Incontinent Care and Supplies. The facility must provide incontinent supplies as needed to meet the needs of residents. The cost shall not be passed on to the resident or resident's legal representative or sponsor as it is included in the reimbursement rate. Neither shall such items be billed to other payment sources when reimbursement is being made by Medicaid through the rate as this constitutes a duplication of billing. If, however, the family or resident elects to purchase supplies other than what is provided by the facility, the facility is not obligated to pay for such supplies.

E. Catheters. The facility shall provide all supplies needed to perform intermittent catheterization.

EXCEPTION: Facilities are not required to provide supplies used for inserting indwelling catheters. These indwelling catheters and catheter trays may be purchased through the Medicaid Pharmacy Program or through Medicare if the resident is eligible for Medicare Part B.

F. Laundry. The facility shall provide laundry services, including personal laundry, for residents.

EXCEPTION: Dry cleaning and/or laundering of hand-washable garments is not a provision of this service.

G. Oxygen. The facility shall provide oxygen for use on a temporary or emergency basis. The facility shall also be responsible for arranging for oxygen required on a long term basis. With prior approval and when the resident's condition requires, based on specific criteria of blood gases at room air, the Medicaid program will purchase or rent an oxygen concentrator.

H. Services and Supplies Excluded. Listed below are general categories and examples of items and services that the facility may charge to residents if they are requested:

1. telephone;

2. television/radio for personal use;

3. personal comfort items, including smoking materials, notions and novelties, and confections;

4. cosmetic and grooming items and services in excess of those for which payment is made under Medicaid or Medicare;

5. personal clothing;

6. personal reading matter;

7. gifts purchased on behalf of a resident;

8. flowers and plants;

9. non-covered special care services such as privately hired nurses or aides;

10. private room, except when therapeutically required (for example, isolation for infection control); and

11. specially prepared food requested instead of the food generally prepared by the facility.

I. Requests For Items and Services

1. The facility shall not charge a resident (or his or her representative) for any item or service not requested by the resident.

2. The facility shall not require a resident (or his or her representative) to request any item or service as a condition of admission or continued stay.

3. The facility shall inform the resident (or his or her representative) requesting an item or service for which a charge will be made, that there will be a charge for the item or service and what the charge will be.

4. A facility's general accommodations are rooms shared by two or more residents. Private rooms are not included in the vendor payments.

J. Ventilator Equipment

1. The Louisiana Medicaid Program will cover ventilator equipment required by dually eligible Medicare and Medicaid recipients in nursing facilities as this is not a covered service under Medicare. Medicaid cannot provide this equipment to individuals in a skilled nursing facility

until after 20 days have elapsed from the nursing facility admit date.

2. Department of Health and Hospitals encourages the nursing facility staff to work with families in returning life-saving equipment (such as ventilators) to the nursing facility for use by other Medicaid residents.

K. Multiple Billing and Arrangements For Services Not Included in The Vendor Payment. The facility shall not bill the resident or responsible party for services or supplies included in the vendor payment.

1. All Medicaid benefits available must be utilized before residents or responsible parties can be charged for services in the facility. This includes payment for reserving beds.

a. The nursing facility may bill residents or their responsible parties for reserving beds after the Medicaid Program limits at the Medicaid rate are exceeded.

b. Facilities shall not impose policies regarding bed reservations which are more restrictive than BHSF regulations.

L. Oxygen Concentrator. The facility may request authorization for payment of an oxygen concentrator from the Durable Medical Equipment Program.

1. The medical criteria used to determine need follows the same requirements established by Medicare.

2. The medical criteria used is available in written form from the Health Standard Regional Office upon request.

NOTE: Items purchased through the Medicaid Durable Medical Equipment (DME) Program shall not be included in the facility's cost report.

M. Colostomy Bags and Colostomy Equipment. These items may be purchased with prior authorization from the Medicaid Program or through Medicare if the patient is eligible for Medicare Part B.

N. Payor of Last Resort. Medicaid is the payor of last resort. Charges shall not be made to the Medicaid Program for any benefits for which the resident is eligible under Title XVIII (Medicare) or other third party insurance coverage.

O. Sitters. A facility shall neither expect nor require a resident to have a sitter. The use of sitters shall be entirely at the discretion of the resident or his legal representative or sponsor. Family members may also elect to use sitters unless the resident or his/her legal representative or sponsor expresses a contrary intent.

1. The facility shall not be responsible for paying the sitter.

2. A sitter shall be expected to abide by the facility's rules and regulations, including health standards and professional ethics. The facility shall provide written notice of violations to the resident, his/her legal representative or sponsor any family member who hired the sitter and to the BHSF-HSS Regional Office.

3. Prescence of a sitter does not absolve the facility of its full responsibility for the resident's care.

4. Office of Secretary to furnish the Bureau of Health Services Financing-Health Standards Section with an initial cost report from the date of purchase or lease to the new fiscal year end selected by the new legal entity. Thereafter, the facility shall file a cost report annually on the purchaser's designated year end.

P. Cost Report. Facilities shall be required to submit cost reports within 90 days from their fiscal year end. A separate report must be completed and submitted for all related: a) home office, b) central office and/or, c) management company costs included in the nursing home cost report. Facilities may select any annual period of cost reporting purposes. However, once a facility has made a selection and reported accordingly, the cost report is to be submitted on the same due date unless a change in the reporting period is approved by the BHSF.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10151. Cost Reports

A. Initial Cost Report. The initial cost report submitted by all providers of Long Term Care services under the Medicaid Program shall be based on the most recent fiscal year end.

1. An exception to the initial cost report requirement may be recognized on an individual basis upon request by the provider prior to the due date. If an exception is allowed, the provider shall attach to the cost report a statement fully describing the nature of the exception for which written permission was requested and granted.

2. For the initial reporting period only, the provider may allocate costs to the various cost centers on a reasonable basis if the required departmental cost breakdown is not available.

B. Subsequent Cost Reports. Subsequent cost reports shall be submitted annually by each provider within 90 days of the close of its normal fiscal year end.

C. Changes of Ownership. In the event of a change in ownership of the facility, the old entity operating the facility shall be required to submit a final cost report from the date of its last fiscal year end to the date of sale or lease.

1. If the new legal entity continues the operations of the facility as a provider of Medicaid services, the new legal entity shall be required to furnish the BHSF-HSS with an initial cost report from the date of purchase or lease to the new fiscal year end selected by the new legal entity.

EXAMPLE: Ms. New purchased Facility A from Mr. Old on September 1, 1985. Facility A's fiscal year end prior to the sale was December 31. Mr. Old is required to file a cost report for the period January 1, 1985 through August 31, 1985. If Ms. New decides to change Facility A's fiscal year end to June

30, her first report shall be due for the 10 month period ending June 30, 1986 and annually thereafter.

a. Furthermore, when a facility changes ownership on or after October 1, 1985, the Consolidated Omnibus Budget Reconciliation Act limits evaluation of facility assets to the acquisition costs of the previous owner increased by 50 percent of the Consumer Price Index or 50 percent of Nursing Facility Construction Cost Index, whichever is lower.

b. In auditing cost reports, DHH will apply this HIM-15 regulation in determining actual cost applicable to sales.

c. If full disclosure of the facts has not been made to the Department of Health and Hospitals and the Department of Health and Hospitals approves a transaction, such approval is qualified on the basis of the facts presented. Any questions concerning a relatedness situation should be directed in writing to Bureau of Health Services Financing.

2. New Facilities

a. A new facility is defined as a newly constructed facility, a facility not currently participating in the Medicaid program or a Medicaid program facility which has been certified for a higher level of care.

b. A new facility may select an initial cost reporting period of at least one month but not to exceed 13 months.

c. Thereafter, the cost reports shall be submitted as in subsequent cost reports described above.

EXAMPLE: A new facility began Medicaid participation on September 15, 1985. The owner wishes to adopt a reporting period ending September 30. The owner must file a report for the period September 15, 1985 to September 30, 1986. He/She cannot file a report for the 15-day period ending September 30, 1985.

NOTE: Facilities purchased as ongoing concerns are not considered new facilities for Medicaid purposes.

3. Final Cost Reports. When a provider ceases to participate in the Medicaid Program, he/she must file a cost report covering a period up to the effective date the facility ceases to participate in the program. Depending upon the circumstances involved in the preparation of the provider's final cost report, the provider may file for a period not less than one month and not more than 13 months.

4. Due Date Extensions. If the facility experiences unavoidable difficulties in preparing its cost report by the prescribed due date, one 30 day extension may be permitted upon written request to the Bureau of Health Services Financing Medicaid Program prior to the due date. Extensions beyond the 30 day time limit may be approved for situations beyond the facility's control. An extension of the cost report due date cannot be granted when the provider agreement is terminated or a change in ownership occurs.

5. Basis of Accounting.

a. All cost report information shall be submitted in accordance with generally accepted accounting principles (GAAP) as well as state and federal regulations. The accrual method of accounting is the only acceptable method for private providers. State institutions shall be allowed to submit data on the cash basis.

b. General ledger accounts should follow the Chart of Accounts previously provided each participating facility.

8. Related Party Transactions. Chapter 10 of HIM-15 explains the treatment of cost(s) applicable to services, facilities, and supplies provided to the facility by organizations related by common ownership or control. The Medicaid Cost Report can only include the actual cost(s) to the related organization for those services, facilities, and supplies. The cost(s) must not exceed the price of comparable services, facilities, or supplies that could be purchased elsewhere.

9. Cost Report Form. The cost report form shall be used by all private providers of nursing facility services. State institutions shall use the same form with additional information for covered ancillary services. All providers shall determine allowable costs utilizing the Standards for Payment Manual and the Medicare Provider Reimbursement Manual (HIM-15) instructions provided with the cost report form.

10. Financial Records. All providers who elect to participate in the Medicaid Program shall maintain all financial and statistical information necessary to substantiate cost data for three years following submission of the cost report or until all audit exceptions are resolved, whichever period is longer. All providers are required to make these records available upon demand to representatives of the state or federal health agencies or their contractual representatives.

11. Allowable Costs

a. Allowable costs for reimbursement to Long Term Care Facilities providing services under Medicaid shall follow the general provisions outlined in the HIM-15.

b. For costs to be allowable, they must be reasonable and related to resident care. The reasonableness of all allowable costs shall be assessed by the BHSF with input from the Audit Contractor, industry representatives, and other interested parties.

c. Allowable cost limits are listed below. More comprehensive explanations of these allowable costs are included in the HIM-15.

12. Salaries. Allowable costs for salaries for Administrator, Assistant Administrator, and other facility managers are limited to the maximum set by the state based on the audit contractors review of cost reports statewide, regardless of the size of the nursing facility.

13. Related Travel Expenses. Reasonable travel expenses are allowable only as related to administration of the facility and resident care.

14. Insurance. Insurance rates are allowable for ordinary and necessary coverage and shall be limited to a

reasonable price in addition to any interim increases initiated by the insurance company.

15. Interest. Necessary and proper interest on both current and capital indebtedness is allowable and shall be limited to that which can be specifically related to the purchase of an asset or is necessary for the operation of the facility.

16. Motor Vehicles. Depreciation and interest expenses are allowable for certain types of motor vehicles if limited to the statewide average list price published at the beginning of each fiscal year by the Bureau of Health Services Financing. This list includes a new standard size auto or van depreciated over 36 months at the prevailing new auto interest rate charged by lending institutions.

a. Lease costs are limited to charges over 36 months by bank-related leasing companies or actual lease costs, whichever is less.

b. Vehicle taxes, tags, titles and insurance charges may be claimed as an allowable cost in the year paid.

c. All use of such vehicles shall be related to patient care or administration of the facility.

d. The following types of vehicles are specifically disallowed:

i. recreational vehicles;

ii. pickup trucks equipped for camping; and

iii. airplanes and boats.

17. Rent. Rents paid to unrelated parties in accordance with HIM-15 are allowable costs. Rental payments between related parties are not allowable costs. Costs of ownership, such as depreciation, interest, etc. may be included in the cost report.

18. Dues. Reasonable dues to one professional trade association or organization are considered an allowable cost.

19. Management Fees and Central Office Overhead

a. Contracts for management services are allowable costs. They shall specify exactly what services are covered by the fee.

b. The charges by a related management firm are limited to actual cost which shall not exceed what the service would cost from unrelated management companies.

NOTE: If a facility's management fees/central office overhead costs are the results of related party transactions, the provider shall submit a separate cost report for the related management company/central office. Salaries shall be limited to Civil Service maximums.

20. Nurse Assistant Training. There shall be a supplemental cost report for nurse aide training and these costs shall not be included in the regular cost report.

21. Owner's Compensation. All types of owners' compensation costs are allowable based on the following limitations.

a. The position filled by the owner is normal to the industry.

b. The salary paid to the owner is in line with employees' salaries for similar positions as shown in the paragraph entitled Salaries.

c. Facility records document shows that the owner does perform the service for which he/she is being compensated.

22. Depreciation. Only the straight-line method of depreciation shall be allowed.

NOTE: Depreciation of assets being used by a vendor at the time he enters the Medicaid program is allowed. This applies even though such assets be fully or partially depreciated on the vendor's books. As long as an asset is being used, its useful life is considered not to have ended. Consequently, the asset is subject to depreciation based on a revised estimate of the asset's useful life as determined by the provider and approved by the Medicaid program.

23. Costs Not Allowable

a. Dues paid to more than one professional trade association or organization, bad debts, unreasonable costs, costs not related to resident care, fines and penalties, and related party costs in excess of actual costs are examples of unallowable costs.

b. Nursing facilities are not to show any cost relating to ventilator equipment in their cost reports to Bureau of Health Services Financing.

c. In cases where nursing service expense at the various levels of care is not kept separate, the following formula may be used for allocating these costs:

i. step one, multiply the number of resident days at each level of care by the weighted factor;

NOTE: The factor represents the number of nursing hours required per patient day at each level of care.

ii. step two, compute the weighted percentage of patient days for each level of care;

iii. step three, apply the percentage computed in step two to the total nursing service expense for the period;

iv. step four, the result obtained in step three is carried to the appropriate schedule of the cost report.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

§10153. Audits, Inspections, Reviews

A. General. Facilities shall be subject to audits, inspections of the quality of care provided, and review of each applicant/recipient's need for SN-NRTP, SN-TDC, SN-ID, SN, IC I, or IC II services.

B. Audits. All nursing facility providers participating in the Medicaid Program shall be subject to audit. A sufficient representative sample of each type of Long Term Care provider shall be fully audited to ensure the fiscal integrity

of the program and compliance with program regulations governing reimbursement. Limited scope and exception audits shall be conducted as needed. The facility shall retain such records or file as required by the Department of Health and Hospitals-Bureau of Health Services Financing and shall have them available for inspection for three years from the date of service or until all audit exceptions are resolved, whichever period is longer.

NOTE: If the department's limited scope audit of the residents' Personal funds account indicate a material number of transactions were not sufficiently supported or material non-compliance, the department shall initiate a full scope audit of the account. The cost of the full scope audit shall be withheld from the vendor payments. (Refer to Subchapter L, Sanctions and Appeal Procedures.)

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

Subchapter G. Levels of Care

§10154. Nursing Facility Level of Care Determinations

A. The purpose of the level of care (LOC) determination is to assure that individuals meet the functional and medical necessity requirements for admission to and continued stay in a nursing facility. In addition, the LOC determination process assists persons with long-term or chronic health care needs in making informed decisions and selecting options that meet their needs and reflect their preferences.

B. In order for an individual to meet nursing facility level of care, functional and medical eligibility must be met as set forth and determined by the Office of Aging and Adult Services (OAAS). The functional and medical eligibility process is frequently referred to as the "nursing facility level of care determination."

C. OAAS shall utilize prescribed screening and assessment tools to gather evaluation data for the purpose of determining whether an individual has met the nursing facility level of care requirements as set forth in this Subchapter.

D. Individuals who are approved by OAAS, or its designee, as having met nursing facility level of care must continue to meet medical and functional eligibility criteria on an ongoing basis.

E. A LOC screening conducted via telephone shall be superseded by a face-to-face minimum data set (MDS) assessment, minimum data set for home care (MDS-HC) assessment, or audit review LOC determination as determined by OAAS or its designee.

F. If on an audit review or other subsequent face-to-face LOC assessment, the LOC findings are determined to be incorrect or it is found that the individual no longer meets level of care, the audit or subsequent face-to-face LOC assessment findings will prevail.

G. The department may require applicants to submit documentation necessary to support the nursing facility level of care determination.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Division of Long Term Supports and Services, LR 32:2083 (November 2006), amended by the Office of Aging and Adult Services, LR 34:1032 (June 2008), amended by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:341 (January 2011), LR 39:1471 (June 2013).

§10155. Standards for Levels of Care

A. Classifications of care are established to ensure placement of residents in Long Term Care Facilities with available and appropriate resources to meet their social psychological, psychological, and biophysical needs.

B. Classifications of care are established with consideration of the resident as a person with innate dignity and worth as a human being.

C. Classifications of care are defined and established so that a resident's total needs, the complexity of the services rendered, and the time required to render these services be assessed in determining placement.

D. Classifications of care are established to prevent placement of residents in facilities where they would present a danger to themselves or other residents.

E. Classifications of care are established to maintain health care so residents achieve a reasonable recovery, maintain a current level of wellness, or experience minimal health status deterioration.

F. Facility Submission of Data. Evaluative data for medical certification for IC I, IC II, and SNF levels of care shall be submitted to the appropriate Bureau of Health Services Financing-Health Standards, Admission Review Unit. This includes data for the following situations:

1. initial applications and reapplication;

2. applications for residents already in long term care facilities;

3. transfers of residents from one level to another;

4. transfer of residents between facilities; and

5. applications for residents who are residents in a mental health facility.

a. All applicants for admission to a nursing facility must be screened for indications of mental illness or mental retardation prior to admission to the nursing facility. This is done by submitting the information requested on Forms 90-L and PASARR-1.

G. Nursing Hours Required

1. The facility will staff for any residents on pass and/or bed hold for hospitalization.

2. Private pay residents must be staffed at the highest level of care unless the level of care is determined by the attending physician.

3. The facility shall provide a minimum nurse staffing pattern and ratio for each level of care as follows.

a. Skilled service shall provide a minimum nurse staffing pattern over a 24 hour period at a ratio of 2.6 hours per skilled resident.

b. Intermediate care services shall provide a minimum licensed nurse staffing pattern over a 24 hour period of 2.35 hours per resident medically certified at the intermediate level.

c. NRTP/Rehabilitation 5.5; NRTP/Complex 4.5.

d. TDC 4.5.

e. Skilled ID 4.0.

4. Intermediate Care I. *Intermediate Care I* is defined as follows:

a. This is a medium level of care provided to Medicaid recipients residing in nursing facilities. The conditions requiring this level of care are characterized by a need for monitoring of moderate intensity. Care shall be provided by qualified facility staff or by ancillary health care providers under the supervision of a registered nurse or licensed practical nurse in accordance with physician's orders. This care shall be available to residents on a 24 hour a day basis.

b. Intermediate Care I services is determined by the following:

i. The resident shall need services in order to attain and maintain a maximum level of wellness.

ii. Care usually considered IC II can become IC I if there are complicating circumstances.

iii. A resident may have multiple conditions, any one of which could require only IC II level of care, but the sum total of which would indicate the need for IC I level of care.

NOTE: Examples of IC I Services (not all inclusive):

Administration of oral medications and eye drops;
Special appliance: Urethral catheter care;
Colostomy care;
Surgical dressings;
Care of decubitus ulcers which are not extensive;
Dependence on staff for a majority of personal care needs;
Bed or chair bound;
Frequent periods of agitation requiring physical or chemical restraints;
Combined sensory defects (e.g. blindness, deafness, significant speech impairment);
Care of limbs in cast, splints, and other appliances;
Post surgical convalescence;
Incontinence of bladder and/or bowel;
Recent history of seizures;
Need for protective restraints;
Use of oxygen occasionally;
Frequent monitoring and recording of vital signs;
Need for physical therapy; and
Uncommunicative or aphasic and unable to express needs adequately.

5. Intermediate Care II. Intermediate Care II is defined as follows:

a. This is a level of care provided to Medicaid recipients residing in nursing facilities characterized by the need for monitoring of less intensity than Skilled Nursing or Intermediate Care I. This care shall be such that it can be given by facility staff (trained aides and orderlies) who are monitored by and under the supervision of licensed nurses in accordance with physician's orders. These residents require care by licensed personnel for 12 hours a day during daylight hours.

NOTE: Examples of IC II Services (not all inclusive):
Supervision or assistance with personal care needs;
Assistance in eating;
Administration of medication, eye drops, topical applications which can be given in a 12 hour period;
Injections given less frequently than daily or for which a rigid time schedule is not important;
Prophylactic skin care or treatment of minor skin problems in ambulatory residents;
Protection from hazards;
Mild confusion or withdrawal;
Medications for stable conditions or those requiring monitoring only once a day; and
Stable blood pressure requiring daily monitoring.

6. Skilled Nursing Facility Within a NF (Distinct Part SNF Unit). Skilled nursing facilities must provide 24 hour nursing services. Except where waived, the services of a registered nurse is required at least eight consecutive hours a day, seven days a week. The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care. Nursing services are not included under "shared services." The distinct part SNF must demonstrate the capacity to provide the services, facilities, and supervision required by SNF requirements of participation.

H. Skilled Nursing Care

1. This is the classification of care provided to Medicaid recipients residing in nursing facilities. The conditions requiring this classification of care are characterized by a need for intensive, frequent, and comprehensive monitoring by professional staff.

2. This care shall be such that it can only be given by a registered nurse or licensed practical nurse or under the supervision and observation of such persons in accordance with physician's orders.

3. This care shall be available to residents only on a 24 hour a day basis.

4. An individual shall be determined to meet the requirements for the SNF classification of care in a nursing facility when the following criteria based on current needs are met. These criteria are meant to be objective, self-explanatory, and universally applicable.

a. The individual requires nursing, psychosocial, or rehabilitation services, i.e., services that must be performed by or under the supervision of the professional health

personnel; e.g., registered nurse, licensed practical nurse, physical therapist, occupational therapist, speech pathologist or audiologist, or a combination thereof.

b. The individual requires such services on a regular basis (seven days per week). Rehabilitation services must be at least five days per week.

I. Services Requiring Supervision of Professional Personnel. The following services are those which are considered to require the supervision of professional personnel (including but not limited to):

1. intravenous, intramuscular, or subcutaneous injections;

2. levine tube and gastrostomy feedings;

3. insertion, sterile irrigation and replacement of catheters as adjunct to active treatment of a urinary tract disease;

4. application of dressings involving prescription medications and sterile techniques;

5. nasopharyngeal or tracheostomy aspiration;

6. treatment of decubitus ulcers, of a severity Grade three or worse, or multiple lesions of a lesser severity;

7. heat treatments (moist) specifically ordered by a physician as part of active treatment done by physical therapist;

8. initial phases of a regimen involving administration of medical gases such as bronchodilator therapy;

9. rehabilitation nursing procedures, including the related teaching and adaptive aspects of nursing, i.e. bowel and bladder training;

10. care of a colostomy during the immediate postoperative period in the presence of associated complications;

11. observation, assessment, and judgement of professional personnel in presence of an unstable or complex medical condition and to assure safety of the resident and/or other residents in cases of active suicidal or assaultive behavior; and

12. therapy (at least five times per week):

a. physical therapy;

b. speech therapy; and

c. occupational therapy (in conjunction with another therapy.

i. Documentation must support that skilled services were actually needed and that these services were actually provided on a daily basis.

J. Skilled Id Nursing Care For AIDS. These residents have a clinical diagnosis of Human Immunodeficiency Virus (HIV) infection and related conditions which require 24 hour a day skilled nursing care.

1. Facility Responsibilities. The facility shall:

a. aggressively meet the medical needs of a predominantly young population who have a terminal illness;

b. provide comprehensive skilled nursing care and related services for residents who require constant nursing intervention and monitoring. The staff shall have specialized training and skills in the care of persons with HIV;

c. develop policy to govern the comprehensive skilled nursing care and related medical or other services provided. This includes a physician, registered nurse, and any other staff responsible for the execution of such policies;

d. have an established plan to insure that the health care of every resident is under the supervision of a licensed physician interested and experienced in the primary care of persons with HIV;

e. make provision to have a licensed physician available to make frequent visits and to furnish necessary medical care in cases of an emergency;

f. make provisions to have 24 hour access to services in an acute care hospital;

g. maintain clinical records on all residents and maintain the confidentiality of such records to the highest extent possible;

h. provide 24 hour nursing service sufficient to meet the complex nursing needs with registered nurse coverage 24 hours per day, seven days per week as the plan of care indicates;

i. provide appropriate methods and procedures for dispensing and administering medications and biologicals which shall also include a protocol for experimental pharmaceutical use;

j. provide policy, procedure, and ongoing education for enhanced universal precautions, be responsible for keeping policy update on current trends for universal precautions related to infectious diseases as outlined by the Center for Disease Control (CDC), and develop specific policies (Practices and Precautions) for preventing transmission of infection in the work-place including employee health issues;

k. provide social services sufficient to meet the mental, psychosocial, behavioral, and emotional needs of the resident. These services shall be provided by a social worker with at least a master level degree from an accredited school of social work and who is licensed as applicable by the state of Louisiana, who shall provide a minimum of two hours per week of services per resident;

l. provide dietary services to meet the complex and comprehensive nutritional needs of the resident. These services shall be provided by registered dietician who shall provide at least one hour per week per resident, but in no case less than four hours per month;

m. provide a dynamic activity program congruent with the needs and ages of the resident which includes an exercise program when indicated to promote and maintain the residents tolerance level to daily activity levels;

n. provide and/or arrange transportation services to meet the medical needs of the resident;

o. provide for the resident the opportunity to participate in the coordination and facilitation in the service delivery and personal treatment plan;

p. provide care plan meetings and updates as often as necessary as necessary by the residents changing condition;

q. provide for appropriate consultation and services to meet the needs of the resident including but not limited to: oncology, infectious diseases, hematology, neurology, dermatology, gastro-enterology, thoracic, gynecology, pediatrics, mental health and/or any other specialized services as indicated;

r. develop respiratory therapy protocols. The respiratory therapist shall work with other medical staff to assure compliance. These services shall be provided as often as necessary by a respiratory therapist either contractually or full-time employment for no less than eight hours per month;

s. provide physical therapy and other rehabilitative services as necessary to meet the special needs of the resident with sensory perception deficit (touch, hearing, sight, etc.);

t. provide and/or arrange through community resources for legal and/or pastoral services an needed by the resident;

u. provide a component of care related to personality changes and communication problems brought on as the illness progresses;

v. provide for access to volunteers and community resources;

w. provide for access to "significant others" to participate in the emotional support and personal care services;

x. Provide a minimum daily average of 4.0 actual nursing hours per resident.

2. Determination of Skilled Nursing Services for Aids. An individual shall be determined to meet the requirements for SN-ID HIV classification of care in a Long Term Care facility when the following criteria, based on current needs are met. These criteria are meant to be objective, self-explanatory, and universally applicable.

3. Payment or reimbursement is not made just because of a diagnosis of AIDS or being HIV+. The payment is intended to be reimbursement for the additional expenses of administering IV therapy and the additional RN hours required to provide this type of therapy in the nursing facility.

a. Enhanced level of universal precautions based on resident needs (blood and body fluid precautions)

b. Continuous ongoing education regarding disease process, infection control, medication, side effects, etc.

4. These services are in conjunction with the following:

a. intermittent or continuous IV therapy, respiratory therapy, nutritional therapy, or other intervention;

b. administration of highly toxic pharmaceutical and experimental drugs which include monitoring of side effects;

c. continuous changes in treatment plan for symptom control;

d. daily medical/nursing assessment for residents changing condition;

e. continuous monitoring for:

i. tolerance level;

ii. skin integrity;

iii. bleeding;

iv. persistent diarrhea;

v. pain intensity;

vi. mental status;

vii. nutritional status; and

viii. tuberculosis (monthly sputum for AFB).

5. The following related conditions may also require SNF ID LOC for HIV:

a. opportunist infections;

i. pneumocystis carnii pneumonia (PCP);

ii. mycobacterium avium-intracellular complex (MAC);

iii. cytomegalovirus;

iv. cyptocpccus neoformans;

v. strongylcides stercoralis

b. non-opportunistic infections:

i. mycobacterium tuberculosis;

ii. pyogenic bacteria (staphylococcus, Streptococcus, etc.); and

iii. histoplasmosis;

c. Malignancies—Kaposi's Sarcoma;

d. opportunistic gastrointestinal infections:

i. Cyptosporidium;

ii. Isospora Belli; and

iii. Malabsorption Syndrome with progressive malnutrition;

e. neurological complications:

i. progressive multi-focal leukoencephalopathy;

ii. brain abscesses;

iii. acute encephalitis;

iv. vascular accident;

v. toxoplasmosis; and

vi. retinopathy.

K. Infectious Disease For Methicillin-Resistant Staphylococcus Aureus (MRSA)—Determination of Skilled Nursing Services for MRSA

1. The following resident criteria for reimbursement of services under the Infectious Disease (MRSA) rate must be met to establish the need for care at this designation. These criteria are meant to be objective, self-explanatory, and applicable to those residents seeking care at this designation. The resident shall:

a. have a positive MRSA culture (symptomic). Symptoms may be manifested locally or systemically and include but not limited to: Erthema, edema, cellulitis, abcessed furuncles, carbuncles, septicemia, osteomyelitis, purulent drainage, elevated white count, elevated temperature, wound infections or urinary infections;

b. require IV antibiotic therapy given in the nursing facility or a hospital;

c. require comprehensive skilled nursing;

d. require that isolation procedures be initiated and maintained as the plan of care dictates.

2. Facility responsibilities to residents at this level of care designation shall:

a. meet the medical nursing needs of residents having MRSA and maintain documentation of such care;

b. have laboratory confirmation of a diagnosis of MRSA done by a laboratory certified by national standards;

c. collect specimens for culture utilizing acceptable techniques or arrange for this to be done by a laboratory. This shall be done as soon as the facility becomes aware of infection and includes but is not limited to drainage from skin lesions, blood, sputum, urine, and aspirations;

d. institute isolation procedures immediately when a resident with indications of MRSA is admitted to the facility or there is an infection identified in-house using the Center for Disease Control (CDC) guidelines. These procedures shall be initiated even if the physician has not seen the resident or been contacted. These procedures shall be fully documented;

e. have physician orders for each resident that are specific for each resident's situation. Standing orders shall not be used without the physicians approval for each individual resident;

f. be expected to insure that IV vancomycin will be initiated under physician order when MRSA has been identified in an active infection with tissue invasion. This therapy can be given within the hospital or in the nursing facility. Exceptions to vancomycin treatment may be made for debilitated and very aged resident(s), a history of sensitivity to this agent, and end state renal disease. Any reason for exception to IV vancomycin therapy must be described in detail the resident's chart and a copy of this documentation provided to Health Standards. There is no assurance that an exception will be granted;

NOTE: The intent for the insertion of the "exception" portion of the Declaration of Emergency document was to remove the appearance of mandating that physicians must treat MRSA residents with IV antibiotics (Vancomycin) under all conditions and circumstances, fully realizing that there would be conditions and circumstances in which Vancomycin could not or would not be given. Payment or reimbursement shall not be made in any case where the resident did not receive the I.V. medication for whatever the reason. Each case requesting an exception will be reviewed on an individual basis. The payment is intended to be reimbursement for the additional expenses of administering IV antibiotics and 24-hour RN coverage. It is not paid just because of the diagnosis of MRSA. Isolation in itself is not a reason for payment for SN-ID, as other diseases require isolation procedures and are not reimbursed as SN-ID.

g. provide IV therapy in the nursing facility only with RN coverage 24 hours a day under a registered nurse employed by the facility and with appropriate laboratory monitoring;

h. provide continuous nursing assessment of any change in the resident's status or therapy;

i. provide aggressive wound care and other indicated nursing care. This must be administered by nurses skilled in these procedures and documentation maintained;

j. provide social services by a masters level social worker and a registered dietician as dictated by the plan of care;

k. provide equipment, supplies, and teaching necessary for significant others to visit the residents;

l. evaluate an individual who is an asymptomatic carrier of MRSA with a complicating problem (example: tracheostomy, gastrostomy, colostomy) for need for IV vancomycin therapy;

m. have policy, procedures, and ongoing education for enhanced universal quality assurance infection control;

n. be responsible for maintaining facility policies updated with current trends in infection control as outlined by the Center for Disease Control;

o. develop specific policies, practices, and precautions for preventing transmission of infection in the facility for protection of residents and employees;

p. have training based on CDC guidelines for MRSA for facility staff responsible for infection control.

3. Requirements for Participation. The facility shall:

a. be currently enrolled to provide nursing services for the treatment of methicillin-resistant staphylococcus aureus; and

b. sign the addendum to the Provider Agreement for participation in the NF-Infectious Disease (MRSA) level of care designation.

4. Certification Requirements. The following medical certification requirements must be met in addition to the Forms 90-L and 148.

a. The facility data submission shall follow the guidelines published for the levels of care.

b. The following additional information requirements must be met:

i. date of onset of MRSA infection;

ii. physicians' orders (specific to each resident's care relating to MRSA infection);

iii. request for a change in level of care to provide treatment for MRSA;

iv. laboratory reports verifying the diagnosis of MRSA;

v. detailed description including measurements of the lesions on tissue involvement; and

vi. documentation that appropriate isolation procedures were carried out (description) from date of the level of care request.

5. Reimbursement Requirements

a. The level of care change request must be approved.

b. Request for changes in the resident's level of care from MRSA level to the former level of care must be completed promptly.

c. The infectious disease reimbursement rate will be paid during the hospital stay.

L. Skilled Infectious Disease; Tuberculosis Multiple Drug Resistant Tuberculosis. This is a Medicaid program (Title XIX) which was developed in conjunction with the TB Control Section of the Department of Public Health. The purpose of the program is to meet the needs of Louisiana citizens who require specialized care for the treatment of tuberculosis of the respiratory tract who are sputum positive for the Tuberculosis germ and who cannot be treated on an out-resident basis for whatever reason.

1. Determination of SN-ID; Tuberculosis. The resident shall:

a. be referred to the nursing facility only by the Tuberculosis Section of the Louisiana Department of Public Health;

b. have a diagnosis of active tuberculosis of the respiratory tract;

c. have an infection caused by the Mycobacterium tuberculosis or Mycobacterium bovis, but not by other mycobacterial species (atypical Tuberculosis);

d. require 24 hour specialized skilled nursing care;

e. be treated under the umbrella of guidelines from the Tuberculosis Section of the Department of Public Health and monitored by the regional tuberculosis clinician;

f. require that immediate isolation procedures be initiated and that the resident not be released from isolation until three sputum smears collected on consecutive days have been negative for acid-fast bacilli. Thereafter, sputum will be monitored at least biweekly or whenever symptoms recur or worsen. If the sputum smear again becomes positive for acid-fast bacilli, isolation will be immediately re-instituted;

g. be admitted and discharged by the public health officer;

h. have 24 hour security guard when needed.

2. Facility Responsibilities

a. The nursing facility shall be approved by the Tuberculosis Section of the Public Health Department to care for SN-ID Tuberculosis residents.

b. The approval shall include as having appropriate "Source-Control Methods" ventilation systems to prevent Tuberculosis bacilli transmission in accordance with federal, state, and local regulations for environmental discharges.

c. Shall monitor at appropriate intervals the ventilation system to maintain effective control of possible transmission of the Tuberculosis bacilli.

d. Initiate, update, and maintain vigorous infection control policy and procedures to manage the infectious/contagious disease process according to current trends established by the Centers for Disease Control and Prevention.

e. Shall employ or contract with an engineer or other professional with expertise in ventilation or other industrial hygiene. This person shall work closely with the Infection Control Committee in the control of airborne infections.

f. Achieve, maintain, and document compliance with all requirements outlined in the Minimum Standards for Nursing Facilities and the enhanced requirements for SN-ID.

g. Shall inform the Regional Tuberculosis Clinician if the resident becomes intolerant of Tuberculosis medications or refuses Tuberculosis medications.

3. Facility Requirements for Participation

a. The facility shall be enrolled as a provider of the Nursing Facility/Infectious Disease (SN-ID) program with appropriate Provider Agreements to participate.

b. The facility shall be currently enrolled to provide nursing facility services to the level of care designation for the treatment of tuberculosis.

c. The facility has been designated by Tuberculosis Control of the Public Health Department to provide SN-ID Tuberculosis care to those residents referred by them.

M. The following medical certification requirements shall be met in addition to the Forms 148, 90-l and PASARR.

1. The facility data submission shall follow the guidelines established for the level of care.

2. The following additional information requirements must be met:

a. outside information consisting of summary of drug therapy prior to admission, past, and present history of non-tubercular illness such as diabetes, previous drug reactions, laboratory test results, and any previous eye or VII cranial nerve tests (auditory and equilibrium);

b. physician orders specific to Infection Control for tuberculosis and other infectious diseases including but not limited to HIV and Staphylococcus Aureus/Methicillin resistant staph Aureus infections;

c. documentation to support that appropriate isolation procedures were implemented on admission.

3. Reimbursement Requirements

a. The 90-L, level of care, and PASARR must be approved by the Department of Health and Hospitals, Health Standards Section.

b. Request for change in level of care when the resident is discharged from the SN-ID Tuberculosis level shall be submitted within five working days.

c. The SN-ID TB reimbursement rate is not applicable to residents who have a non-pulmonary/respiratory diagnosis or who have atypical mycobacteriosis or who have a conversion of skin test without positive sputum.

d. The SN-ID tuberculosis reimbursement rate will be paid during a hospital stay up to the customary ten day bed hold policy.

N. Rehabilitation and Complex Levels of Care

1. These levels of care were developed to provide services and care to residents who have sustained severe neurological injury or who have conditions which have caused significant impairment in their ability to independently carry out activities of daily living. Residents shall have, based upon a physicians assessment, the potential for regaining a level of functioning which is feasible. Significant practical improvement must be expected in a prescribed or predetermined period of time. An expectation of complete independence in the activities of daily living is not necessary, but there must be a reasonable expectation of improvement that will be of practical value to the resident measured against his/her condition at the start of care.

2. Rehabilitation services are designed to reduce the resident's rehabilitation and medical needs while restoring the person to an optimal level of physical, cognitive, and behavioral function within the content of the person, family, and community.

3. Complex care services are designed to provide care for residents who have a variety of medical/surgical concerns requiring a high skill level of nursing, medical and/or rehabilitation interventions to maintain medical/functional stability.

O. Rehabilitation and Complex Levels of Care

1. These levels of care were developed to provide services and care to residents who have sustained severe neurological injury or who have conditions which have caused significant impairment in their ability to independently carry out activities of daily living. Residents shall have, based upon a physician=s assessment, the potential for regaining a level of functioning which is feasible. Significant practical improvement must be expected in a prescribed or predetermined period of time. An expectation of complete independence in the activities of daily living is not necessary, but there must be a reasonable expectation of improvement that will be of practical value to the resident measured against his/her condition at the start of care.

2. The health conditions of the individuals who qualify for either of these levels of care are too medically complex or demanding for a typical skilled nursing facility, but no longer warrant care in an acute setting. Reimbursement is available under the Title XIX program for a period not to exceed 90 days if medical eligibility criteria established by the department have been met. Extensions may be requested in 30-day increments up to a maximum of three extensions based on documentation contained in progress reports. Level of care certification cannot exceed a total of six months. The Health Standards Section shall review the documentation submitted by the facility and determine if the applicant meets the criteria for admission certification and continued stay at these levels of care.

3. The rehabilitation and complex levels of care shall utilize the *Consumer Price Index for All Urban ConsumersXSouthern Region, All Items Economic Adjustment Factors*, as published by the United States Department of Labor to give yearly inflation adjustments. This economic adjustment factor is computed by dividing the value of All Items index for December of the year preceding the rate year (July 1 through June 30) by the value of the All Items index one year earlier (December of the second preceding year). This factor, All Items, will be applied to the total base which excludes fixed cost. Rebasing and interim adjustments to rates shall be calculated in the same manner as for regular nursing facilities.

4. Annual financial and compliance audits are required from the providers of these services. Additional cost reporting documents as requested by the department may also be required. Providers are required to segregate these costs from all other nursing facility costs and submit a separate annual cost report for each level of care (rehabilitation and complex care services). Medicare cost

principles found in the Provider Reimbursement Manual (HIM-15) shall be used to determine allowable costs.

P. Criteria for Certification of SN Rehabilitation and SN-Complex Level of Care, and Provision of Services

1. Medical Eligibility Criteria for Certification of SN-Rehabilitation Level of Care. Residents seeking skilled services at the SN Rehabilitation level of care shall meet all of the following criteria:

a. require an intense, individualized rehabilitation program designed to address severe neurological deficits (not due to a psychiatric disorder) caused from an injury or neurological condition which shall have occurred within six months from the date of admission;

b. have a severe loss of function (not secondary to behavioral deficits) in activities of daily living, mobility, and communication with the potential for significant practical improvement as measured against his/her condition prior to rehabilitation;

c. shall be capable of participating in a minimum of two hours of active (not passive) rehabilitation (OT, PT, ST) per day;

d. require a minimum of 5.5 hours of nursing care per day. Monitoring of behaviors by attendants cannot be considered as meeting the required nursing hours;

e. require aggressive medical support and a coordinated program of care delivered through a multidisciplinary team approach;

f. demonstrate documented, measurable progress toward the reduction of physical, cognitive and/or behavioral deficits to qualify for continued funding at this level of care.

2. Exclusionary Criteria for SN-Rehabilitation Services. Residents meeting any one of the following criteria do not qualify for this level of care:

a. the resident has already participated in a comprehensive rehabilitation effort on an inpatient basis either in an acute care setting or other type of rehabilitation facility;

b. the resident has a neurological condition which is considered to be progressive in nature and where no practical improvement can be expected (e.g., Huntington's Chorea);

c. the resident requires medication adjustment or attention to psychological problems related to a neurological condition or injury but has the ability to carry out the basic activities of daily living;

d. the resident lives out of state and has access to rehabilitation services in his/her state of residence;

e. the resident does not have sufficient mental alertness to actively participate in the program;

f. the resident has a major psychiatric disorder (schizophrenia, manic-depression, etc.) which precludes active participation;

g. the resident with an uncomplicated CVA whose needs can be met at the skilled level of care.

3. Medical Eligibility Criteria for Certification of SN-Complex Level of Care. Residents seeking skilled services at the complex level of care shall meet all of the following criteria:

a. have a neurological injury/condition resulting in severe functional, cognitive and/or physical deficits which shall have occurred within six months from the date of admission;

b. require a level of care and services which are not able to be provided in a typical skilled nursing facility or on an outpatient basis. Facility documentation must specify why an alternative setting is inappropriate or inadequate to meet the needs of the resident;

c. require a minimum of 4.5 hours of nursing care per day;

d. shall be capable of participating in a minimum of two hours of active (not passive) rehabilitation per day.

4. Provision of Therapy Services for SN Rehabilitation and Complex Level of Care. Therapy services must be rendered on a per resident basis by a licensed therapist. Skilled therapy services must meet all of the following conditions:

a. the services must be directly and specifically related to an active written treatment plan designed by the physician after any needed consultation with a multidisciplinary team including a licensed therapist(s);

b. therapies shall be available and provided at least five days per week. If the resident is unable to participate or refuses to participate, the facility shall document the reason for nonparticipation and shall promptly notify the Health Standards Section;

c. the services must be of a level of complexity and sophistication, or the condition of the resident must be of a nature that requires the judgment, knowledge, and skills of a licensed therapist(s);

d. the services must be provided with the expectation, based on the assessment made by the physician of the resident's restoration potential, that the condition of the resident will improve materially in a reasonable and generally predictable period of time, not to exceed 90 days, or the services must be necessary for the establishment of a safe and effective maintenance program which can be continued after discharge;

e. the services must be considered under accepted standards of medical practice to be specific and effective treatment for the resident's condition;

f. the services must be reasonable and necessary for the treatment of the resident's condition; this includes the requirement that the amount, frequency, and duration of the services must be reasonable and not able to be provided in a less restrictive setting such as outpatient. Documentation by the facility must support that rehabilitation services are

actually needed on an inpatient basis. When the resident has behavior or physical limitations that cannot be modified any further, the level of care shall be discontinued. There must be significant practical improvement as measured against the condition or injury prior to the episode which resulted in admission—significant improvement being the ability to self-perform activities of daily living;

g. therapy cannot be provided at the skilled level of care. The medical record shall document why the therapy cannot be provided at a lower level of care;

h. recreational therapies shall not be included when determining compliance with the required number of hours of therapy a day.

5. Criteria for Discharge from the Rehabilitation and Complex Levels of Care

a. there is evidence in the medical record that the resident has achieved stated goals;

b. medical complications preclude an intensive rehabilitation effort. Any regression or deterioration in the resident's medical condition shall immediately be reported to the Health Standards Section;

c. multidisciplinary therapy is no longer needed;

d. no additional practical improvement in function is anticipated;

e. the resident's functional status has remained unchanged for 14 days;

f. the resident has received services for 90 days;

g. if the resident exhibits inability or refuses to participate in therapy, this shall constitute termination of rehabilitation services and/or recertification for level of care. Discharge shall be initiated when the resident fails to participate in five consecutive therapy sessions during a two-week period;

h. the resident has an established behavior management plan.

Q. Documentation Requirements for Vendor Payment

1. Documentation Requirements for the Determination of Medical Eligibility for Vendor Payment. The following documentation requirements shall be submitted to the Health Standards Section for consideration of medical certification at either the rehabilitation or complex levels of care:

a. Form 148 (Notification of Admission/Change);

b. Form 90-L (Request for Level of Care Determination);

c. Level I PAS/RAS (Pre-admission Screening/ Re-admission Screening);

d. history of current condition;

e. presenting problems and current needs;

f. if transferring from an acute care hospital, all therapy evaluations, therapy progress reports, physician's orders and physician progress notes;

g. assessments done by facility field evaluators;

h. evaluations done by all facility therapists participating in the individual treatment plan;

i. preliminary plan of care including services to be rendered; plan should specify frequency, responsible discipline, and projected time frame for completion of each goal.

2. Documentation of Progress. The facility shall document, in detail, progress in meeting goals.

a. Progress reports shall be submitted to the Health Standards office every 30 days. Progress reports shall address the resident's ability to self-perform activities of daily living. If there is no progress in this area, it shall be so stated.

b. Active discharge planning shall be addressed in all progress reports. If the established goal is to return home, involvement by family members or significant others shall be noted in progress reports.

c. It is not necessary that progress reports recapitulate events resulting in admission.

d. It is the responsibility of the facility to promptly notify the Health Standards Section when goals have been achieved or the resident is not making progress toward meeting established goals, regardless of the amount of time in the program.

R. Facility Responsibilities for Participation. The facility seeking to provide services under the rehabilitation and complex level of care must meet all of the following requirements:

1. be licensed to provide nursing facility services and shall admit and maintain residents requiring any nursing facility level of care designation;

2. have a valid Medicaid Program provider agreement for provision of nursing facility services;

3. have entered into a contractual agreement with the Bureau of Health Services Financing to provide rehabilitation and complex care services;

4. be accredited by the Joint Commission on Accreditation on Health Care Organizations (JCAHO) and by the Commission on Accreditation of Rehabilitation Facilities (CARF);

5. have appropriate rehabilitation services to manage the complex functional and psychosocial needs of the residents and appropriate medical services to evaluate and treat the pathophysiologic process. The staff shall have intensive specialized training and skills in rehabilitation;

6. provide an interdisciplinary team of professionals to direct the clinical course of treatment. This team shall include, but is not limited to a physician, registered nurse,

physical therapist, occupational therapist, speech/language therapist, respiratory therapist, psychologist, social worker, recreational therapist, and case manager;

7. ensure that the health and rehabilitation needs of every resident in certified for rehabilitation/complex level of care shall be under the supervision of a licensed physiatrist, board-certified or board-eligible in physical medicine and rehabilitation;

8. have policies and procedures to ensure that a licensed physician visits and assesses each resident's care frequently but no less than weekly;

9. have formalized policies and procedures to furnish necessary medical care in cases of emergency and provide 24-hour-a-day access to services in an acute care hospital;

10. have established policies to screen residents who are not appropriate for the program according to the Medicaid medical eligibility criteria or whose needs the facility cannot meet;

11. have each resident assigned to a facility case manager to monitor, measure, and document goal attainment and functional improvement. The case manager shall be responsible for cost containment and appropriate utilization of services. Coverage should stop when further progress toward the established rehabilitation goals are unlikely or can be achieved in a less intensive setting;

12. assure that discharge planning is an integral part of the rehabilitation program and should begin upon the resident's admittance to the facility. Plans of care must be individualized and aggressive with regard to the projected time frame for discharge. When progress notes show that the resident has not made significant, measurable progress from one review period to the next or that the condition cannot be modified any further, Medicaid will not authorize further reimbursement for rehabilitation. Significant progress should be the ability to self-perform or require only minimal to moderate assistance to perform activities of daily living;

13. provide private rooms for residents demonstrating extraordinary medical and/or behavioral needs. Dedicated treatment space shall be provided for all treating disciplines including the availability of distraction-free individual treatment rooms and areas;

14. provide 24-hour nursing services to meet the medical and behavioral needs with registered nurse coverage 24 hours per day, seven days a week. Management of the resident's daily activities shall be under the direct supervision of a registered nurse;

15. provide appropriate methods and procedures for dispensing and administering medications and biologicals that are in accordance with the organizations issuing the facility's accreditations;

16. have formalized policies and procedures for ongoing staff education in rehabilitation, respiratory, specialized medical services, and other related clinical and nonclinical issues. Staff education shall be provided on a regular basis;

17. provide dietary services to meet the comprehensive nutritional needs of the residents. These services shall be provided under the direction of a registered dietician who shall consult a minimum of two hours per month;

18. provide families/significant others the opportunity to participate in the coordination and facilitation of service delivery and individual treatment plan;

19. provide nonmedical and nonemergency medical transportation services and arrange for medical transportation services to meet the medical/social needs of the residents;

20. provide initial and ongoing integrated, interdisciplinary assessments to develop treatment plans which should address medical/neurological issues such as sensorimotor, cognitive and perceptual deficits, communicative capacity, affect/mood, interpersonal and social skills, behaviors, ADLs, recreation/leisure skills, education/vocational capacities, sexuality, family, legal competency, adjustment to disability, post-discharge services environmental modifications, and all other areas deemed relevant for the individual;

21. assure that the interdisciplinary team meets in conference at least every 14 days to update the individual treatment plan but as often as necessary to address the changing needs of the client;

22. provide appropriate consultation services to meet the needs of clients, including, but not limited to, audiology, orthotics, prosthetics, or any other specialized services;

23. establish a protocol for ongoing contact with professionals in vocational rehabilitation education, mental health, developmental disabilities, Social Security, medical assistance, head injury advocacy groups and any other relevant community agencies;

24. establish protocols to provide for a close working relationship with acute care hospitals capable of caring for persons with brain and upper spinal cord injuries to provide post discharge follow-up, in-service education and on-going training of treatment protocols to meet the needs of residents;

25. establish written policies and procedures to address referrals coming from out of state. The facility must provide written explanation as to what steps were taken to obtain services within the state of residence and why the services were not available or inadequate to meet the needs of the resident. The facility shall seek reimbursement for all level of care services from the state of residence or referral prior to making application for Louisiana Medicaid.

S. Change in Level of Care Within a NF. The facility shall be responsible for submitting current medical information to the HSS Regional Office for approval of level of care change when recommended by the attending physician. Form 149-B shall be completed when making the request for change. This procedure shall be followed whether the change is within the facility or requires a move to another facility. The facility shall have five working days

to submit Form 149-B to the Health Standards Section for both upgrade and downgrade in level of care. The effective date of medical certification will be the date the physician signs the Form 149-B. If the facility fails to submit the request timely, the certification will be the date the Form 149-B is received in the HSS Regional Office. A statement from the physician in lieu of Form 149-B is not acceptable when requesting level of care change. If applicable, notice is also required when a resident transfers to Medicare skilled level. The state will pay co-insurance beginning on the twenty-first day.

1.-2.t. Reserved.

u. require staff to attend specialized training on ventilator assisted care if the facility provides SN-TDC services to Medicaid recipients from birth through age 25. The training will be conducted by a contractor designated by the department. The facility shall also cooperate with ongoing monitoring conducted by the contractor. Training content includes:

i. the special health needs of, and risks to ventilator-dependent recipients;

ii. the proper use and maintenance of equipment in use or new to the facility;

iii. current, new, or unusual health procedures and medications;

iv. diagnoses and treatments specific to pediatrics and in the development and nutritional needs of recipients;

v. emergency intervention;

vi. accessing school services for ventilator-assisted recipients; and

vii. discharge planning where families express interest in a recipient returning home.

2.v. - 3.e. Reserved.

T. Change in Level of Care Within a NF. The facility shall be responsible for submitting current medical information to the HSS Regional Office for approval when the attending physician recommends a change in the level of care. Form 149-B shall be completed when making the request for a level of care change. This procedure shall be followed whether the change is within the facility or whether the change requires a transfer to another facility. A statement from the physician, in lieu of Form 149-B, is not acceptable.

1. The facility shall have 20 working days to submit Form 149-B to the Health Standards Section for both upgrades and downgrades in level of care. If submitted within the 20 working day time frame, the effective date of change in medical certification will be the date the physician signs the Form 149-B.

2. If the facility fails to timely submit the request, the effective date of the medical certification will be the date the Form 149-B is received in the HSS Regional Office.

3. The completion of the Form 149-B is also required when a resident transfers to Medicare skilled level.

4. The Medicaid Program will pay co-insurance beginning on the twenty-first day.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996), LR 23:970 (August 1997), 24:457 (March 1998), LR 29:911 (June 2003).

§10156. Level of Care Pathways

A. Several potential avenues of functional and medical eligibility shall be investigated by OAAS. These avenues are called pathways. The pathways are utilized to ensure consistency, uniformity, and reliability in making nursing facility level of care determinations. In order to meet the nursing facility level of care, an individual must meet eligibility requirements in only one pathway.

B. When specific eligibility criteria are met within a pathway, that pathway is said to have triggered. The Medicaid program defines nursing facility level of care for Medicaid eligible individuals as the care required by individuals who meet or trigger any one of the established level of care pathways described in this Subchapter. The pathways of eligibility focus on information used to determine if an individual has met or triggered a level of care pathway. When a pathway is triggered, that individual may be approved for a limited stay/length of service as deemed appropriate by OAAS.

C. The level of care pathways elicit specific information, within a specified look-back period, regarding the individual's:

1. functional capabilities;

2. receipt of assistance with activities of daily living (ADL);

3. current medical treatments and conditions; and

4. other aspects of an individual's life.

D. Activities of Daily Living Pathway

1. The intent of this pathway is to determine the individual's self-care performance in activities of daily living during a specified look-back period (e.g., the last seven days, last three days, etc. from the date the LOC assessment was completed) , as specified in prescribed screening and assessment tools.

2. The ADL Pathway identifies those individuals with a significant loss of independent function measured by the amount of assistance received from another person in the period just prior to the day the LOC assessment was completed.

3. The ADLs for which the LOC assessment elicits information are:

a. locomotion—moving around in the individual's home;

b. dressing—how the individual dresses/undresses;

c. eating—how food is consumed (does not include meal preparation);

d. bed mobility—moving around while in bed;

e. transferring—how the individual moves from one surface to another (excludes getting on and off the toilet and getting in and out of the tub/shower);

f. toileting—includes getting on and off the toilet, wiping, arranging clothing, etc.;

g. personal hygiene (excludes baths/showers); and

h. bathing (excludes washing of hair and back).

4. Since an individual can vary in ADL performance from day to day, OAAS trained assessors shall capture the total picture of ADL performance over the specified look-back period.

5. In order for an individual to be approved under the ADL Pathway, the individual must score at the:

a. limited assistance level or greater on toilet use, transferring, or bed mobility; or

b. extensive assistance level or greater on eating.

E. Cognitive Performance Pathway.

1. This pathway identifies individuals with the following cognitive difficulties:

a. short term memory which determines the individual's functional capacity to remember recent events;

b. cognitive skills for daily decision making which determines the individual's actual performance in making everyday decisions about tasks or activities of daily living such as:

i. planning how to spend his/her day;

ii. choosing what to wear; or

iii. reliably using canes/walkers or other assistive devices/equipment, if needed;

c. making self understood which determines the individual's ability to express or communicate requests, needs, opinions, urgent problems, and social conversation, whether in speech, writing, sign language, or a combination of these (includes use of word board or keyboard).

2. In order for an individual to be approved under the cognitive performance pathway, the individual must have any one of the conditions noted below:

a. be severely impaired in daily decision making (never or rarely makes decisions);

b. have a short term memory problem and daily decision making is moderately impaired (e.g., the individual's decisions are consistently poor or unsafe, cues or supervision is required at all times);

c. have a memory problem and is sometimes understood (e.g., the individual's ability is limited to making concrete requests);

d. have a short-term memory problem and is rarely or never understood;

e. be moderately impaired in daily decision making (e.g., the individual's decisions are consistently poor or unsafe, cues or supervision is required at all times) and the individual is usually understood (e.g., the individual has difficulty finding words or finishing thoughts and prompting may be required);

f. be moderately impaired in daily decision making (e.g., the individual's decisions are consistently poor or unsafe, cues or supervision is required at all times) and the individual is sometimes understood, (e.g., his/her ability is limited to making concrete requests);

g. be moderately impaired in daily decision making (e.g., the individual's decisions are consistently poor or unsafe, cues or supervision is required at all times) and the individual is rarely or never understood;

h. be minimally impaired in daily decision making (e.g., the individual has some difficulty in new situations or his/her decisions are poor and requires cues and supervision in specific situations only) and the individual is sometimes understood (e.g., the individual's ability is limited to making concrete requests); or

i. be minimally impaired in daily decision making (e.g., the individual has some difficulty in new situations or his/her decisions are poor, cues and supervision are required in specific situations only) and the individual is rarely or never understood.

F. Physician Involvement Pathway

1. The intent of this pathway is to identify individuals with unstable medical conditions that may be affecting his/her ability to care for himself/herself.

2. The following are investigated for this pathway:

a. physician visits occurring during the 14-day look-back period (excluding emergency room exams); and

b. physician orders issued during the 14-day look-back period (excluding order renewals without change and hospital inpatient visits).

3. In order for an individual to be approved under the physician involvement pathway, the individual must have:

a. one day of doctor visits and at least 4 new order changes within the 14-day look-back period; or

b. at least 2 days of doctor visits and at least 2 new order changes during the 14-day look-back period.

4. Supporting documentation is required and must include:

a. a copy of the physician's orders; or

b. the home health care plans documenting the diagnosis, treatments and conditions within the designated time frames; or

c. the appropriate form designated by OAAS to document the individual's medical status and condition.

G. Treatments and Conditions Pathway

1. The intent of this pathway is to identify individuals with unstable medical conditions that may be affecting a person's ability to care for himself/herself.

2. The following are investigated for this pathway:

a. stage 3-4 pressure sores during the 14-day look-back period;

b. intravenous feedings during the 7-day look-back period;

c. intravenous medications during the 14-day look-back period;

d. daily tracheostomy care and ventilator/respiratory suctioning during the 14-day look-back period;

e. pneumonia during the 14-day look-back period and the individual had associated need for assistance with IADLs, ADLs, or restorative nursing care;

f. daily respiratory therapy provided by a qualified professional during the 14-day look-back period;

g. daily insulin injections with two or more order changes during the 14-day look-back period; or

h. peritoneal or hemodialysis during the 14-day look-back period.

3. In order for an individual to be approved under the treatments and conditions pathway, the individual must have:

a. any one of the conditions listed in G.2.a-h above; and

b. supporting documentation for the specific condition(s) identified. Acceptable documentation must include:

i. a copy of the physician's orders; or

ii. the home health care plans documenting the diagnosis, treatments and conditions within the designated time frames; or

iii. the appropriate form designated by OAAS to document the individual's medical status and condition.

H. Skilled Rehabilitation Therapies Pathway

1. The intent of this pathway is to identify individuals who have received, or are scheduled to receive physical therapy, occupational therapy or speech therapy.

2. In order for an individual to be approved under this pathway, the individual must:

a. have received at least 45 minutes of active physical therapy, occupational therapy, and/or speech therapy during the seven-day look-back period; or

b. be scheduled to receive at least 45 minutes of active physical therapy, occupational therapy, and/or speech therapy scheduled during the seven-day look-forward period.

3. Supporting documentation of the therapy received/scheduled during the look-back/look-forward period is required and must include:

a. a copy of the physician's orders for the received/scheduled therapy;

b. the home health care plan notes indicating the received/scheduled therapy;

c. progress notes indicating the physical, occupational, and/or speech therapy received;

d. nursing facility or hospital discharge plans indicating the therapy received/scheduled; or

e. the appropriate form designated by OAAS to document the individual's medical status and condition.

I. Behavior Pathway

1. Effective upon promulgation of this Rule, the behavior pathway will be eliminated as a pathway for meeting nursing facility level of care.

2. Individuals receiving services who met the nursing facility level of care only by triggering the behavior pathway prior to promulgation of this Rule shall continue to remain eligible for services requiring nursing facility level of care until:

a. the individual is discharged from long term care services; or

b. the individual has been found eligible for services in another program or setting more appropriate to their needs.

J. Service Dependency Pathway

1. The intent of this pathway is to identify individuals who are currently in a nursing facility or receiving services through the Adult Day Health Care Waiver, the Community Choices Waiver, Program of All Inclusive Care for the Elderly (PACE) or receiving long-term personal care services.

2. In order for individuals to be approved under this pathway, the afore-mentioned services must have been approved prior to December 1, 2006 and ongoing services are required in order for the individual to maintain current functional status.

3. There must have been no break in services during this time period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing and the Office of Aging and Adult Services, LR 37:342 (January 2011), amended LR 39:1471 (June 2013), LR 41:1289 (July 2015), amended by the Department of Health, Bureau of Health Services

Financing and the Office of Aging and Adult Services, LR 43:2187 (November 2017), LR 44:1019 (June 2018).

Subchapter H. Reserved

Subchapter I. Resident Rights

§10161. General Provisions

A. The resident has a right to a dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility. A facility must protect and promote the rights of each resident.

B. Exercise of Rights

1. The resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

2. The resident has the right to be free of interference, coercion, discrimination, and reprisal from the facility in exercising his or her rights.

3. In the case of a resident adjudged incompetent under the laws of a state by a court of competent jurisdiction, the rights of the resident are exercised by the person appointed under state law to act on the resident's behalf.

C. Civil Rights Act Of 1964 (Title VI)

1. Title VI of the Civil Rights Act of 1964 states No person in the United States shall, on the grounds of race, color, or national origin, be excluded from participation in, be denied the benefits of, or subjected to discrimination under any program or activity receiving federal financial assistance.

2. Nursing facilities shall meet the following criteria in regard to the above-mentioned Act.

a. Compliance. Facilities shall be in compliance with Title VI of the Civil Rights Act of 1964 and shall not discriminate, separate, or make any distinction in housing, services, or activities based on race, color, or national origin.

b. Written Policies. Facilities shall has written policies and procedures that notify the community that admission to the facility, resident care services, and other activities are provided without regard to race, color, or national origin.

c. Community Notification. Facilities shall notify the community that admission to the facility, resident care services, and other activities are provided without regard to race, color, or national origin. Notice to the community may be given by letters to and meeting with physicians, local health and welfare agencies, paramedical personnel, and public and private organizations having interest in equal opportunity. Notices published in newspapers and signs posted in the facility may also be used to inform the public.

D. Section 504 Of The Rehabilitation Act Of 1973. Facilities shall comply with Section 504 of the Rehabilitation Act of 1973 which states the following: No qualified handicapped person shall, on the basis of handicap, be excluded from participation in, be denied the benefits of, or otherwise be subjected to discrimination under any program or activity which receives or benefits from federal financial assistance.

E. Age Discrimination Act of 1975. This Act prohibits discrimination on the basis of age in programs or activities receiving federal financial assistance. All facilities must be in compliance with this Act.

F. Notice Of Rights and Services. All residents or legal representative shall sign a statement that they have been fully informed verbally and in writing in a language that the resident understands of the following information prior to or at the time of admission and when changes occur during their stay in the facility:

1. the facility's rules and regulations;

2. their rights;

3. their responsibilities to obey all reasonable rules and regulations and respect the personal rights and private property of other residents;

4. rules for conduct at the time of their admission and subsequent changes during their stay in the facility;

a. changes in resident rights policies shall be conveyed both verbally and in writing to each resident at the time of or prior to the change, and acknowledged in writing.

b. the resident or his/her legal representative has the right:

i. upon an oral or written request to access all records pertaining to himself or herself including clinical records within 24 hours; and

ii. after receipt of his/her records for inspection to purchase, at a cost as set forth in LA R.S. 40:1299.96, photocopies of the records or any portions of them upon request and two working days advance notice to the facility;

5. the resident has the right to be fully informed in a language that he/she can understand of his/her total health status including but not limited to his/her medical condition;

6. the resident has the right to:

a. refuse medication and medical treatment including a physician visit, other than to discover and prevent the spread of infection of contagious disease to protect environmental health and hygiene or otherwise indicated by the attending physician and to be informed of the consequences of such actions; and

b. refuse to participate in experimental research;

c. refuse to formulate an advance directive;

7. exercise of this resident's right does not include the refusal to perform reasonable hygiene measures (i.e., bathing, shampooing, oral care);

a. the facility must:

i. inform each resident who is entitled to Medicaid benefits in writing at the time of admission to the

nursing facility of when the resident becomes eligible for Medicaid; of

(a). the items and services that are included in nursing facility services under the State Plan and for which the resident may not be charged by providing a copy of the Department of Health and Hospitals Blue Book;

(b). those other items and services that the facility offers and for which the resident may be charged, and the amount of charges for those services;

ii. inform each resident when changes are made to these items and services;

iii. inform each resident before or at the time of admission and periodically during the resident's stay, of services available in the facility and of charges for those services, including any charges for services not covered under Medicare/Medicaid or by the facility's per diem rate;

iv. furnish a written description of legal rights which includes:

(a). a description of the manner of protecting personal funds as outlined in this document on pages 216 through 220;

(b). a description of the requirements and procedures for establishing eligibility for Medicaid, including the right to request an assessment which determines the extent of a couple's non-exempt resources at the time of institutionalization and attributes to the community spouse an equitable share of resources which cannot be considered available for payment toward the cost of the institutionalized spouse's medical care in his/her process of spending down to Medicaid eligibility levels;

(c). a posting of names, addresses, and telephone numbers of all pertinent state client advocacy groups such as the Bureau of Health Services Financing-Health Standards Section, the State Ombudsman Program, the Protection and Advocacy Network, and the Medicaid Fraud Control Unit;

(d). a statement that the resident may file a complaint with the Bureau of Health Services Financing-Health Standards Section concerning resident abuse, neglect, and misappropriation of resident property in the facility;

v. inform each resident of the name, specialty, and way of contacting the physician responsible for his/her care;

vi. prominently display in the facility written information and provide to residents and applicants on admission oral and written information about how to apply for and use Medicare and Medicaid benefits and how to receive refunds for previous payments covered by such benefits.

G. Notification of Changes. A facility must inform or make a reasonable attempt to notify the resident's legal representative or interested family member when there is:

1. an accident involving the resident which results in injury and has the potential for requiring physician intervention;

2. a significiant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);

3. a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences or to commence a new form of treatment;

4. a decision to transfer or discharge the resident from the facility;

5. documentation of the notification or attempts in notification shall be entered in the medical record.

a. The facility must also notify the resident and the resident's legal representative or sponsor when there is:

i. a change in room or roommate assignment. Notification must be given at least 24 hours before the change and a reason for the move shall be given to all parties. Documentation of this shall be entered in the medical record;

ii. a change in resident rights under state law or regulations.

H. Involuntary Admittance. Residents shall not be forced to enter or remain in a nursing facility against their will unless they have been judicially interdicted.

I. Delegation Of Rights

1. Resident rights and responsibilities are passed on to a guardian, next of kin, sponsor, responsible party, or sponsoring agency in the following instances:

a. when a competent individual chooses to allow another to act for him/her. (Example: Power of Attorney);

b. when the resident is adjudicated incompetent in accordance with state law.

2. The physician and the facility must be aware of, address, and document specific information concerning the incapability of the resident to understand and exercise their rights even if the resident has been adjudicated incompetent.

3. The following documentation is required:

a. administrative documentation;

i. the relation of the resident to the person assuming his rights and responsibilities;

ii. that the responsible person can act for the resident; and

iii. the extent of a guardianship or Durable Power of Attorney;

b. physician documentation;

i. a statement that the resident is not capable of understanding and exercising his rights;

ii. specific causative and/or contributing medical diagnosis(es); and

iii. medical observations and tests which support the diagnosis(es).

EXAMPLES: Alzheimer's Disease and/or Organic Brain Syndrome

J. Management Of Resident Finances. Residents shall have the right to the following options regarding their personal financial affairs.

1. They shall be allowed to manage their personal financial affairs or to designate someone to assume this responsibility for them. They shall be permitted to spend their personal funds as they desire unless interdicted and/or under a curatorship. There shall be no limitations on the use of personal funds so long as the funds are not used to pay for anything covered by the Medicaid program.

2. There is no obligation for a resident to deposit funds with the facility. However, the facility is obliged to hold, safeguard, and account for personal funds upon written request by the resident or his or her representative. This delegation may be only to the extent of the funds held in trust by the facility. The facility does not have the option of refusing to hold, safeguard, or manage resident funds. The facility must comply with the wishes of the resident once written authorization is received.

3. The resident, his or her legal representative shall have access through quarterly statements and on request financial records if the facility has been delegated the responsibility for handling their financial affairs. Upon request the facility shall provide a list or statement regarding personal funds to the parish/regional office of Bureau of Health Services Financing with the resident's written consent. A copy shall be retained in the resident's record.

a. The nursing facility may not require the resident to deposit his/her personal funds with the facility.

b. Once the facility receives the written authorization from the resident, it must safeguard and account for such personal funds under a system established and maintained by the facility. The facility shall have written policies and procedures to protect resident funds. Current facility records shall reflect if residents handle their own funds or the names of parties designated to handle their personal funds.

c. The facility may make arrangements with a federal or state insured banking institution to provide banking services, but the responsibility for the disbursements, quality, and accuracy of required records remains with the facility.

NOTE: Any charge for this service is included in the facility's basic rate.

d. Upon receipt of written authorization of a resident, the facility must manage and account for the personal funds of the resident deposited with the facility as follows.

i. Deposit. The facility must deposit any amount of personal funds in excess of $50 with respect to a resident in an interest bearing account (or accounts) that is separate from any of the facility's operating accounts and credit all interest earned on such separate account to such account. The facility may maintain resident's personal funds that do not exceed $50 in a non-interest bearing account, interest bearing account, or petty cash fund.

ii. Accounting and Records. The facility shall assure a full and complete separate accounting of each such resident's personal funds, maintain a written record of all financial transactions involving the personal funds of a resident deposited with the facility and afford the resident (or legal representative of the resident) reasonable access to such record.

iii. Notice of Certain Balances. The facility must notify each resident receiving medical assistance under Medicaid Program State Plan when the amount in the resident's account reaches $200 less than the dollar amount of resources allowed under SSI policy and the fact that if the amount in the account (in addition to the value of the resident's other non-exempt resources) exceeds the SSI resource limit the resident may lose eligibility for such medical assistance or for benefits under Title XVI (SSI) and Medicaid.

K. Collective Bank Account(s). Collective bank account(s) shall:

1. be for the resident's money;

2. be separate and distinct from all nursing facility accounts;

3. consist of resident's money and shall not be commingled with the facility's operating account; and

4. be regular checking account(s) or interest-bearing account(s). Interest shall be computed to each resident on the basis of actual earnings or end-of-quarter balance.

a. There shall be a monthly reconciliation between the collective or individual bank accounts and the individual resident account(s).

b. The individual financial record must be available through quarterly statements and on request to the resident or his/her legal representative.

L. Resident Fund Accounting System. The facility shall maintain current written individual records of all financial transactions involving the personal funds which the facility is holding, safeguarding, and accounting. The facility shall keep these records in accordance with requirements of law for a trustee in a fiduciary relationship which exists for these financial transactions. The facility shall ensure the soundness and accuracy of the resident fund account system.

1. The facility shall develop the following procedures to ensure a sound and workable fund accounting system.

2. A file shall exist for each participating resident. Each file or record shall contain all transactions

pertinent to the account, including the following information:

a. money received:

i. source;

ii. amount; and

iii. date;

b. money expended:

i. purpose;

ii. amount; and

iii. date of all disbursements to or in behalf of the resident.

3. All monies, either spent on behalf of the resident or withdrawn by the resident or shall be supported by a receipt and cancelled check or signed voucher on file.

NOTE: It is recommended that the functions of actual cash receipt disbursements and recording of cash disbursements be separate.

4. Receipt for disbursements shall include the following information:

a. the date of the disbursement;

b. the amount of the disbursement;

c. the signature of the resident or responsible party; and

d. purpose and payee of disbursement.

NOTE: A running list of disbursements and receipts may be kept for posting on ledger sheets or individual vouchers. The resident's individual ledger sheet shall constitute the necessary receipt in situations where no check has been drawn if the ledger sheet is dated, shows the amount, resident's signature, and has the person's signature responsible for the resident's funds. Cancelled checks are sufficient receipt for disbursements if coupled with information regarding the purpose of the expenditure. When a resident is unable to sign the ledger, it should be signed by the custodian of the fund and two witnesses.

5. The file shall be available to the resident or his or her legal representative upon request during the normal administrative work day.

6. Cash on Hand. The facility shall have a minimum of cash on hand to meet residents' spending needs. Cash on hand shall be maintained on the imprest petty cash system.

7. Ownership of Accounts. The account shall be in a form which clearly indicates that a facility does not have an ownership interest in the funds.

8. Insured Accounts. The account shall be insured under federal and state law.

9. Distribution of Interest. The interest earned in any pooled interest-bearing account shall be distributed in one of the following manners:

a. prorated to each resident on an actual interest-earned basis;

b. prorated to each resident on the basis of his end-of-quarter balance.

10. Surety Bond. The facility shall purchase a surety bond or otherwise provide assurance satisfactory to the Secretary to assure the security of all personal funds of residents deposited with the facility.

11. Closing a Discharged Resident's Fund Account. Nursing facilities shall refund the balance of the resident's personal funds when a resident is discharged. The amount shall be refunded by the end of the month following the month of discharge. Date, check number, and "to close account" should be noted on the ledger sheet.

12. Conveyance Upon Death. Legally the funds should be turned over to the executor of the estate. Within three months the legal representative or sponsor should notify the facility as to whom the executor is. The executor must then open succession. The facility must convey within 30 days the balance of the resident's personal funds account and the unused portion of any advance room and board payment, and a final accounting of those funds to the individual or person administering the resident's estate. In lieu of a lengthy legal process, a facility can obtain an "Affidavit of Small Succession" from the Unclaimed Property Section at the Louisiana Department of Revenue and Taxation for estates involving less than $50,000 and where no real estate is involved. This will allow for transfer of assets to the heirs without a waiting period.

a. The following shall apply in regard to a deceased resident's unclaimed personal funds.

i. If the facility fails to receive notification of the appointment or other designation of a responsible party (legal guardian, administrator or the estate, or person placed in possession by court judgement) within three months after the date of death, the facility shall retain the funds and notify the Public Administrator or Curator of Vacant Successions in the parish where the facility is located. The notice shall provide detailed information about the decedent, his next of kin, and the amount of funds.

ii. The facility shall continue to retain the funds until a court order specifies that the funds are to be turned over to the Public Administrator or Curator of Vacant Successions.

iii. If neither order nor judgement is forthcoming, the facility shall retain the funds for five years after date of death.

iv. Thereafter, the facility is responsible for delivering the unclaimed funds to the Secretary of Revenue and Taxation.

v. A termination date of the account and the reason for termination shall be recorded on the resident's participation file. A notation shall read, "to close account". The endorsed cancelled check with check number noted on the ledger sheet shall serve as sufficient receipt and documentation.

b. Nursing Facility Residents' Burial Insurance Policy. "With the resident's permission, the nursing facility administrator or designee may assist the resident in acquiring a burial policy, provided that the administrator, designee, or affiliated persons derive no financial or other benefit from the resident's acquisition of the policy."

M. Specific Rights

1. Free Choice. The resident has the right to:

a. choose a personal attending physician;

b. obtain pharmaceutical supplies and services from a pharmacy of choice at their own expense or through Medicaid, provided the drugs are delivered timely to the facility and packaged compatibly with a facility's medication administration system;

c. be fully informed in advance about care and treatment and of any changes in that care or treatment that may affect the resident's well-being;

d. unless adjudged incompetent or otherwise found to be incapacitated under the laws of the state participate in planning care and treatment or changes in care and treatment; and

e. withhold payment for a physician's visit if the physician did not perform an examination;

f. to be returned to the nursing facility upon discharge from an acute hospital bed.

2. Privacy and Confidentiality

a. The resident has the right to personal privacy and confidentiality of his or her personal and clinical records.

b. Personal privacy includes accommodations, medical treatment, written and telephone communications, personal care, visits, and meetings of family and resident groups. This does not require the facility to provide a private room for each resident.

i. Privacy shall include:

(a). having closed room doors;

(b). having facility personnel knock on a closed door before entering their room except in an emergency situation or unless medically contraindicated;

(c). having privacy during toileting, bathing, and other activities of personal hygiene except as needed for safety reasons or assistance; and

(d). having privacy screens or curtains in use during treatment, bathing, toileting, or other activities of personal hygiene.

c. Except as provided in the next paragraph, the resident may approve or refuse the release of personal and clinical records to any individual outside the facility.

d. The resident's right to refuse release of personal and clinical records does not apply when:

i. the resident is transferred to another health care institution;

ii. record release is required by law; and

iii. requested by staff from the Department of Health and Hospitals.

e. Grievances. A resident has the right to:

i. voice grievances without discrimination or reprisal. Such grievances include those with respect to treatment which has been furnished as well as that which has not been furnished;

ii. prompt efforts by the facility to resolve grievances the resident may have, including those with respect to the behavior of other residents.

f. Examination of Survey Results. A resident has the right to:

i. examine the results of the most recent survey of the facility conducted by federal or state surveyors and any plan of correction in effect with respect to the facility. The results must be made available for examination by the facility in a place readily accessible;

ii. receive information from agencies acting as recipient advocates and be afforded the opportunity to contact these agencies.

g. Work. The resident has the right to:

i. refuse to perform services for the facility; and

ii. perform services for the facility if he/she chooses when:

(a). the facility has documented the need or desire for work in the plan of care;

(b). the plan specifies the nature of the services performed and whether the services are voluntary or paid;

(c). compensation for paid services is at or above the prevailing rates; and

(d). the resident agrees to the work arrangement described in the plan of care.

h. Mail. The resident has the right to privacy in written communications including the right to:

i. send and promptly receive mail that is unopened; and

ii. have access to stationary, postage, and writing implements at the resident's own expense.

i. Access and Visitation Rights. The resident has the right and the facility must provide immediate access by any resident to the following:

i. any representative of the Secretary of HHS;

ii. any representative of the state;

iii. the resident's individual physician;

iv. the State Long Term Care Ombudsman (established under section 307(a)(12) of the Older Americans Act of 1965);

v. the agency responsible for the protection and advocacy system for developmentally disabled individuals (established under part C of the Developmental Disabilities Assistance and Bill of Rights Act);

vi. the agency responsible for the protection and advocacy system for mentally ill individuals (established under the Protection and Advocacy for Mentally Ill Individuals Act);

vii. subject to the resident's right to deny or withdraw consent at any time, immediate family or other relatives of the resident;

viii. subject to reasonable restrictions and the resident's right to deny or withdraw consent at any time, others who are visiting with the consent of the resident; and

ix. visiting overnight outside the facility with family and friends in accordance with the facility policies, physician's orders, and Title XVIII (Medicare) and Title XIX (Medicaid) regulations without the loss of their bed. Home visit policies and procedures for arranging home visits shall be fully explained.

(a). The facility must provide reasonable access to any resident by any entity or individual that provides health, social, legal, or other services to the resident subject to the resident's right to deny or withdraw consent at any time.

(b). The facility must allow trained compensated representatives of the State Ombudsman to examine a resident's clinical records with the permission of the resident or the resident's legal representative and consistent with state law.

(c). Visiting hours shall be flexible taking into consideration special circumstances such as out-of-town visitors and working relatives and friends. Additionally, the facility shall arrange for critically ill residents to receive visitors other than during normal business hours.

j. Telephone. The resident has the right to have reasonable access to the use of a telephone where calls can be made without being overheard.

k. Personal Property. The resident has the right to retain and use personal possessions including some furnishings and appropriate clothing, as space permits, unless to do so would infringe upon the rights or health and safety of other residents.

l. Married Couples. The resident has the right to share a room with his or her spouse when married residents live in the same facility and both spouses consent to the arrangement.

m. Self-Administration of Drugs. An individual resident may self-administer drugs if the interdisciplinary team has determined that this practice is safe.

n. Choice of Roommate. Residents shall have the right to have their wish respected regarding choice(s) of roommate(s), insofar as possible and/or reasonable.

o. Smoking. Residents shall have the right to use tobacco at their own expense under the facility's safety rules and the state's applicable laws and rules unless the use of tobacco is medically contraindicated as documented in the medical record by the attending physician.

p. Alcoholic Beverages. Residents shall have the right to consume a reasonably amount of alcoholic beverages at their own expense unless the following conditions are present.

i. It is medically contraindicated as documented in the medical record by the attending physician.

ii. It is expressly prohibited by published rules and regulations of a facility owned and operated by a religious denomination which has abstinence from the consumption of alcoholic beverages as part of its religious beliefs.

iii. There is no disruption to other facility residents or staff.

q. Retiring and Rising. Residents shall have the right to retire and rise in accordance with reasonable requests if the following conditions are met:

i. they do not disturb others.

ii. they do not disrupt the posted meal schedule;

iii. upon the facility's request, they remain in a supervised area; and

iv. retiring and rising in accordance with their request is not medically contraindicated as documented in the medical record by the attending physician.

r. Participation in Resident and Family Groups

i. A resident has the right to organize and participate in resident groups in the facility.

ii. A resident's family has the right to meet in the facility with the families of other residents in the facility.

iii. The facility must provide a resident or family group, if one exists, with private space.

iv. Staff or visitors may attend meetings at the group's invitation.

v. The facility must provide a designated staff person responsible for providing assistance and responding to written requests that result from group meetings.

vi. When a resident or family group exists, the facility must listen to the views and act upon the grievances and recommendations of residents and families concerning proposed policy and operational decisions affecting resident care and lift in the facility.

s. Representative Payee

i. Residents receiving Social Security benefits shall have the right to make an application with the Social Security Administration to designate a representative payee.

ii. If residents receiving Social Security benefits are incapable of managing their personal funds and have no legal representative, the facility may notify the Social Security Administration and request that a representative payee be appointed.

N. Violation of Rights. Any person who submits or reports a complaint concerning a suspected violation of residents' rights or concerning services or conditions in a facility or who testifies in any administrative or judicial proceeding arising from such complaint, shall have immunity from any criminal or civil liability therefor unless that person has acted in bad faith with malicious purpose or if the court finds that there was an absence of a justifiable issue of either law or fact raised by the complaining party.

O. Bill of Rights. Resident Bill of Rights shall be prominently displayed in accessible areas at a proper height and in a size print which is appropriate to elderly individuals having impaired vision. The Bill of Rights shall include the following assurances in addition to the above mentioned rights. All facilities shall adopt and make public a statement of the rights and responsibilities of residents residing in the facility and shall treat all individuals in accordance with the provisions of the statement.

1. Each nursing facility shall provide a copy of the statement required by R.S. 40:2010 8(A) to each resident, sponsor, and/or the resident's legal representative upon or before admission to the facility and to each staff member. The statement shall also advise the resident, sponsor, and/or responsible party that the nursing facility is not responsible for the actions or inactions of other persons or entities not employed by the facility, such as the treating physician, pharmacist, sitter, or other such persons or entities employed or selected by the resident, sponsor, and/or responsible party. Each facility shall prepare a written plan and provide appropriate staff training to implement the provisions of R.S. 40:2010.6 et seq., but not limited to explanation of the following:

a. the resident rights and the staff's responsibilities in the implementation of those rights;

b. the staff's obligation to provide all residents who have similar needs with comparable services as required by state licensure standards.

2. Any violation of the residents' rights in R.S. 40:2010.6 et seq. shall constitute grounds for appropriate action by the Department of Health and Hospitals. Residents shall have a private right of action to enforce these rights as set forth in T.S. 40:2010.9. The state courts shall have jurisdiction to enjoin a violation of residents' rights and assess fines for violations not to exceed $100 per individual violation.

P. Civil and Religious Liberties. Residents shall have the right to civil and religious liberties including but not limited to the following:

1. knowledge of available choices;

2. the right to independent personal decisions;

3. the right to encouragement and assistance from facility staff in exercising these rights to the fullest extent possible;

4. the right to participate in social, religious, and community activities that do not interfere with the rights of other residents in the facility; and

5. the resident has the right to exercise his or her rights as a resident of the facility and as a citizen or resident of the United States.

Q. Freedom from Restraints and Abuse. Residents shall have the right to be free from verbal, sexual, physical or mental abuse, corporal punishment, involuntary seclusion, and any physical and chemical restraints imposed for the purpose of discipline or convenience and not required to treat the resident's medical symptoms. Bed-rails used during sleeping hours at the request of the resident's legal representative or responsible party are not restraints. Restraints may only be imposed:

1. to insure the physical safety of the resident;

2. only upon written order of a physician that specifies the duration, type of restraint, and circumstances under which the restraints are to be used except in emergency circumstances;

3. in case of an emergency, physical restraint may only be applied by a qualified licensed nurse who shall document in the medical record the circumstances requiring the necessity for use of the restraint;

4. in case of emergency, a chemical restraint may be used by a qualified licensed nurse if authorized by the attending physician. The necessity for the use of the chemical restraint shall be documented in the medical record as well a monitoring of vital signs after the drug has been administered. In this case, the attending physician shall be consulted immediately thereafter;

a. as needed or PRN antipsychotic drugs should only be used when the resident has a "specific condition" for which antipsychotic drugs are indicated and one of the following circumstances exists:

i. the as needed or PRN does is being used to titrate the resident's total daily dose up or down or is being used to manage unexpected harmful behaviors that cannot be managed without antipsychotic drugs. Under this circumstance, a PRN antipsychotic drug may be used no more than twice in any 7 days period without an assessment or the cause for the resident's behavioral symptoms and the development of a plan of care designed to attempt to reduce or eliminate the cause(s) for the harmful behavior;

5. psychopharmacologic drugs may be administered only on the orders of a physician and only as part of a plan (included in the written Plan of Care) designed to eliminate or modify the symptoms for which the drugs are prescribed (Applicable only to Medicaid residents.);

6. bedrails and geri-chairs, if used for the purpose of restricting free movement, are considered restraints. Before using such methods, the facility should first attempt to use less restrictive alternatives. If these alternatives are found to be ineffective in the context of treating the resident's medical symptoms, the facility may apply them within the context of individualized care planning. The facility should also monitor in a way that promotes the highest practicable physical, mental and psychosocial well-being of the resident. If the use is associated with a decline in the resident's functional ability, such as increased agitation, the interdisciplinary team should reassess the resident's needs;

7. if the restraint is used to enable the resident to attain or maintain his or her highest practicable level of functioning, a facility must have evidence of consultation with appropriate health professionals, such as occupational or physical therapists. The consultation should consider the use of less restrictive therapeutic intervention prior to using restraints for such purposes.

R. Housing

1. All residents shall be housed without regard to race, color, or national origin. Bi-racial occupancy of rooms and wards on a non-discriminatory basis shall be required.

2. Residents shall not be asked if they are willing to share a room with a person of another race, color, or national origin.

3. Resident transfers shall not be used to evade compliance with Title VI of the Civil Rights Act of 1964.

a. Open Admission Policy. An open admission policy and desegregation of facilities shall be required, particularly when the facility previously excluded or primarily served residents of a particular race, color, or national origin. Facilities which exclusively serve residents of one race have the responsibility for taking corrective action, unless documentation is provided that this pattern has not resulted from discriminatory practices.

b. Restricted Occupancy. A facility owned or operated by a private organization may restrict occupancy to members of the organization without violating Civil Rights compliance, provided membership in the organization and admission to the facility is not denied on the basis of race, color, or national origin.

S. Resident Services. All residents shall be provided medical, non-medical, and volunteer services without regard to race, color, or national origin. All administrative, medical, and non-medical services are covered by this requirement.

T. Facility Personnel

1. Attending physicians shall be permitted to provide resident services without regard to race, color, or national origin.

2. Other medical, paramedical, or non-medical persons, whether engaged in contractual or consultative capacities, shall be selected and employed in a non-discriminatory manner. Opportunity shall not be denied to qualified persons on the basis of race, color, or national origin.

3. Dismissal from employment shall not be based upon race, color, or national origin.

U. Advance Directives. Each resident shall be:

a. afforded the opportunity to participate in the planning of his medical treatment;

b. encouraged and assisted throughout his/her period of stay to exercise his/her rights as a patient and as a citizen; and

c. treated with consideration, respect,and full recognition of his/her dignity and individuality.

2. Nursing facilities must:

a. provide all adult individuals with written information about their rights under state law to make health care decisions including the right to accept or refuse treatment and the right to execute advance directives;

b. document in the resident's medical record whether or not he/she has signed an advance directive;

c. not discriminate against an individual based on whether he/she has executed an advanced directive; and

d. provide facility and community with education on advance directives.

NOTE: If an advance directive has been executed, a copy shall be kept in the medical record.

3. Definitions

a. *Attending Physician*—the physician who has primary responsibility for the treatment and care of the resident.

b. *Declaration*—a witnessed document, statement, or expression voluntarily made by the declarant, authorizing the withholding or withdrawal of life-sustaining procedures, in accordance with requirements of Louisiana Law. A declaration may be made in writing, orally, or by other means of nonverbal communication.

c. *Life-sustaining Procedure*—any medical procedure or intervention which within reasonable medical judgement, would serve only to prolong the dying process for a person diagnosed as having a terminal and irreversible condition. A "life-sustaining procedure" shall not include any measure deemed necessary to provide comfort care.

d. *Physician*—a physician or surgeon licensed by the Louisiana State Board of Medical Examiners.

e. *Qualified Resident*—a resident diagnosed and certified in writing as having a terminal and irreversible condition by two physicians, one of whom shall be the attending physician, who have personally examined the resident.

f. *Terminal and Irreversible Condition*—a condition caused by injury, disease, or illness which within reasonable medical judgement, would produce death and for

which the application of life-sustaining procedures would serve only to postpone the moment of death.

4. Written Policy

a. All facilities shall have an appropriate written policy and procedure regarding the decision to have life-sustaining procedures withheld or withdrawn in instances where such residents are diagnosed as having a terminal and irreversible condition.

b. If the policies of a nursing facility preclude compliance with the declaration of a resident or preclude compliance with provisions pertaining to a representative acting on behalf of a qualified resident, the nursing facility shall take all reasonable steps to effect the transfer of the resident to a facility in which the provisions of his/her declaration can be carried out.

5. Facility Responsibility

a. Physician orders shall:

i. be based on the medical examination of the resident's immediate and long-term needs;

ii. document that the condition is terminal and irreversible;

NOTE: Two physicians must document that the resident has a terminal and irreversible condition ("Qualified Resident");

iii. prescribe a planned regimen of total care for the resident which shall include special exceptions to the treatment regimen.

b. Plan of care shall:

i. Include a statement indicating that a valid declaration has been made; and

ii. Include measures to ensure the comfort care of the resident during the dying process.

e. Nursing Notes. Charting shall be done as often as necessary but at least every eight hours during the time that life-sustaining procedures are withheld or withdrawn.

6. Declaration. The declaration may be executed at any time by the individual or legal representative. The declaration is not activated until two physicians determine that the resident has a terminal or irreversible condition. For purposes of clarity in the event the document must be executed, the resident should be advised that it should be specific as to what measures the resident does and does not want.

7. Do Not Resuscitate—DNR Order. If the responsible physician finds that resuscitation would be medically inappropriate, a Do Not Resuscitate (DNR) order becomes effective only upon the informed choice of a competent resident or by agreement of the family members as a class if the resident is incompetent. A signed DNR order must be witnessed by two persons not related by blood or marriage and who would not be entitled to any portion of the estate. The DNR is not a decision that can be made by a physician or facility committee acting alone.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

Subchapter J. Transfer and Discharge Procedures

§10163. General Provisions

A. Health facilities must permit each resident to remain in the facility and not transfer or discharge the resident from the facility unless:

1. the transfer or discharge is necessary for the resident's welfare and the resident's needs cannot be met in the facility;

2. the transfer or discharge is appropriate because the resident's health has improved sufficiently so that the resident no longer needs the services provided by the facility;

3. the safety of individuals in the facility is endangered;

4. the health of individuals in the facility would otherwise be endangered;

5. the resident has failed, after reasonable and appropriate notice, to pay for (or to have paid under Medicare or Medicaid) a stay at the facility; and

6. the facility ceases to operate.

B. When the facility proposes to transfer or discharge a resident under any of the circumstances specified in number one through number five above, the resident's clinical records must be documented. The documentation must be made by the following:

1. the resident's physician when transfer or discharge is necessary as specified in number one or number two as listed above;

2. any physician when transfer or discharge is necessary as specified in number four as listed above.

C. Before an interfacility transfer or discharge occurs the facility must, on a form prescribed by the Louisiana Department of Health and Hospitals, do the following:

1. Notify the resident of the transfer or discharge and the reasons for the move in writing and in a language and manner that the resident understands. The health facility must place a copy of the notice in the resident's clinical record and transmit a copy to the following:

a. the resident;

b. a family member of the resident, if known;

c. the resident's legal representative and legal guardian, if known;

d. the local long term care ombudsman program (for involuntary relocations or discharges only);

e. the person or agency responsible for the resident's placement, maintenance, and care in the facility;

f. in situations where the resident is developmentally disabled, the Regional Office of the Division of Mental Health who may assist with placement decisions; and

g. the resident's physician when the transfer or discharge is necessary under situations as described in number three through six in §10163.A. of this Subchapter;

2. record the reasons in the resident's clinical record;

3. Include in the notice the items as described in number one through eight in §10163.E. of this Subchapter.

D. Except when specified in number one below, the notice of transfer or discharge required in §10163.D of this Subchapter must be made by the facility at least 30 days before the resident is transferred or discharged.

1. Notice may be made as soon as practicable before transfer or discharge when:

a. the safety of individuals in the facility would be endangered as described in number three §10163.A. of this Subchapter;

b. The health of individuals in the facility would be endangered as described in number four in §10163.A. of this Subchapter;

c. The resident's health improves sufficiently to allow a more immediate transfer or discharge as described in number two of §10163.A. of this Subchapter;

d. an immediate transfer or discharge is required by the resident's urgent medical needs; and

e. a resident has not resided in the facility for 30 days.

E. For health facilities the written notice as described in §10163 of this Subchapter must include the following:

1. the reason for transfer or discharge;

2. the effective date of transfer or discharge;

3. the location to which the resident is transferred or discharged;

4. a statement regarding appeal rights that reads: You have the right to appeal the health facility's decision to transfer you. If you think you should not have to leave this facility, you may file a written request for a hearing postmarked within ten days after you receive this notice. If you request a hearing, it will be held within 23 days after you receive this notice, and you will not be transferred from the facility earlier than 30 days after you receive this notice of transfer or discharge, unless the facility is authorized to transfer you as described in number one, §10163.D. of this Subchapter. If you wish to appeal this transfer or discharge, a form to appeal the health facility's decision and to request a hearing is attached. If you have any questions, call the Louisiana Department of Health and Hospitals at the number listed below;

5. the name of the director, and the address, telephone number, and hours of operation of the Bureau of Appeals of the Louisiana Department of Health and Hospitals;

6. a hearing request form utilized by the Louisiana Department of Health and Hospitals;

7. the name, address, and telephone number of the state long term care ombudsman;

8. for health facility residents with developmental disabilities or who are mentally ill, the mailing address and telephone number of the protection advocacy services commission.

F. Appeal of Transfer or Discharge

1. If the resident appeals the transfer or discharge, the health facility may not transfer or discharge the resident within 30 days after the resident receives the initial transfer or discharge unless an emergency exists as described in number one §10163.D.1 of this subchapter. A physician determines that an emergency exists.

2. If non-payment is the basis of a transfer or discharge, the resident shall have the right to pay the balance owed to the facility up to the date of the transfer or discharge and then is entitled to remain in the facility.

3. The Louisiana Department of Health and Hospitals shall provide a resident who wishes to appeal the transfer or discharge from a facility the opportunity to file for a hearing postmarked within ten days following the resident's receipt of the written notice or the transfer or discharge from the facility.

4. If a health facility resident requests a hearing, the Louisiana Department of Health and Hospitals shall hold a hearing at the health facility, or by telephone if agreed upon by all parties, within 30 days from the date the resident receives the notice of transfer or discharge. The Louisiana Department of Health and Hospitals shall issue a decision within 30 days from the date the resident receives the notice. The health facility must convince the Department by a preponderance of the evidence that the transfer or discharge is authorized under Section A. If the Department determines that the transfer is appropriate, the resident must not be required to leave the health facility within 30 days after the resident's receipt of the initial transfer or discharge notice unless an emergency exists as described in number one § 10163.D.1. of this Subchapter.

G. Room to Room transfer (intra-facility). The resident or curator and responsible party shall receive at least a 24 hour notice before the room of the resident is changed. A reason for the move will be given to resident and curator/responsible party. Documentation of all of this information will be entered in the medical record. A resident has the right to receive notice when their roommate is changed.

NOTE: The resident has the right to relocate prior to the expiration of the 24 hours notice if this change is agreeable to him/her.

H. Facility Responsibilities In An Individual Involuntary Transfer or Discharge. Facility responsibilities in ensuring an orderly individual involuntary transfer shall include the following tasks:

1. The facility shall complete a final review and update the plan of care with the transfer in mind. The update shall include review of the following:

a. the discharge plan; and

b. the overall plan of care and current MDS.

2. A discharge plan shall be submitted to the individual or institution into whose care the resident is being discharged. It shall include the following information:

a. nursing services required including needed medications;

b. rehabilitative needs;

c. appropriate level of medical care;

d. any special medical arrangement necessary to alleviate any adverse effects of the discharge;

e. memory and orientation as to time, place, and person; and

f. length of residence in the facility;

g. a discharge plan containing all pertinent information regarding a resident's present condition and documentation showing lack of continued need for the level of care provided by the facility shall be submitted to the Bureau of Health Services Financing-Health Standard Section Regional Office, once the following conditions are met:

i. A medical assessment is made as near as practicable to the date of discharge; and

ii. The attending physician executes a written statement showing that on the basis of the resident's current physical and mental condition, there are no medical contraindications to the discharge.

h. Written Notice of Transfer or Discharge. The written notice of transfer or discharge shall contain the following information:

i. the proposed date of the transfer or discharge and reason(s) for same;

ii. a date, time, and place for a conference;

iii. the nursing home personnel available to assist in locating a new nursing facility or alternate living arrangement; and

iv. the resident's right for personal and/or third party representation at all stages of the transfer or discharge process.

i. Transfer or Discharge Conference. The facility Administrator and/or Nursing Director and/or Social Services Director shall meet with the resident and resident's legal representative or sponsor to discuss the transfer or discharge. The discussion shall be conducted within the following time frames to ensure an orderly process:

i. as soon as possible in advance of the transfer or discharge; but

ii. at least within the written 30 day advance notice time period.

(a). The resident's presence at the conference may be waived with a written statement from the attending physician explaining the medical contraindications for participation in such a meeting.

(b). Discussion should include information outlined above.

j. Pre-Transfer Services. The facility shall provide all pre-transfer services required in the final update of the individual plan of care and transfer or discharge plan.

k. Resident Overstay. The facility is responsible for keeping the resident whenever medical conditions warrant such action for as long as necessary, even if beyond the proposed date of transfer or discharge, except in emergency situations and when payment has been arranged.

l. Transportation. The facility shall arrange for transportation to the new residence.

I. Voluntary Individual Transfer or Discharge. Voluntary Individual Transfer.

1. To the extent possible, facilities shall adhere to the procedures outlined above prior to the actual transfer of residents who voluntarily transfer from one facility to another. The information in the plan of care, MDS, and discharge plan should be submitted to the receiving facility at the request of the resident and/or legal representative.

2. Voluntary Individual Discharge. To the extent possible, facilities shall adhere to the procedures outlined above prior to the actual discharge of residents who voluntarily leave the facility. The information in the care plan, MDS, and discharge plan shall be submitted to the individual or institution into whose care the resident is being discharged at the written request of the resident and/or legal representative.

3. Bed Hold. Before a nursing facility transfers a resident to a hospital or allows a resident to go on therapeutic home leave of 24 hours duration or longer, the nursing facility shall provide written information to the resident and a family member or legal representative that specifies the following:

a. the duration of the bed-hold policy under the State Plan during which the resident is permitted to return and resume residence in the facility; and

b. the health facility's policies regarding bed-hold periods, which must be consistent with §10163.I.3.ii. of this Subchapter.

i. Except in an emergency, at the time of transfer of a resident for hospitalization or therapeutic home leave, a health facility shall provide to the resident and a family

member or legal representative written notice which specifies the duration of the bed-hold policy.

ii. Medicaid certified facilities must establish and follow a written policy under which a resident, whose hospitalization or therapeutic home leave exceeds the bed-hold period under the State Plan, is readmitted to the facility immediately upon the first availability of a bed in a semi-private room if the resident:

(a). requires the services provided by the facility; and

(b). is eligible for Medicaid nursing facility services.

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Subchapter K. Complaint Procedures

§10165. Purpose and Scope

A. Under the provisions of Louisiana R.S. 40:2009.2 through 2009.20 and State Operations Manual as published by the Department of Health and Hospitals and Health Care Financing Administration, the following procedures are established for receiving, evaluating, investigating, and correcting grievances pertaining to resident care in licensed and certified nursing facilities. The following procedures also provide mandatory reporting of abuse and neglect in nursing facilities.

B. Applicability

1. Any person having knowledge of the alleged abuse or neglect of a resident or knowledge of a resident being denied care and treatment may submit a complaint, preferably in writing.

2. Any person may submit a complaint if he/she has knowledge that a state law, standard, rule, regulation, correction order, or certification rule issued by the Department of Health and Hospitals has been violated.

C. Duty to Make Complaints. Any of the following persons who have actual knowledge of a facility's abuse or neglect of a resident, shall submit a complaint within 24 hours:

1. physicians or other allied health professionals;
2. Social Services personnel;
3. facility administration;
4. psychological or psychiatric treatment personnel;
5. registered nurses;
6. licensed practical nurses; and
7. nurse's aides.

D. Penalties for Failure To Make Complaint

1. Any person who knowingly and willfully fails to report an abuse or neglect situation shall be fined not more than $500 or imprisoned not more than six months or both. The same sanctions shall apply to an individual who knowingly and willingly files a false report.

2. Penalties for committing cruelty or negligent mistreatment to a resident of a health care facility shall be not more than $10,000.00 or imprisoning with or without hard labor for more than ten years, or both.

E. Where to Submit Complaint. A complaint may be filed as follows.

1. It may be submitted in writing to the Secretary of the Department of Health and Hospitals or his designee at P.O. Box 94065, Baton Rouge, LA 70804-4065;

2. It may be relayed by calling Health Standards Section at (504) 342-0082;

3. It may be submitted to any local law enforcement agency.

F. DHH's Referral of Complaints for Investigation

1. Complaints involving residents of all ages in institutions received by the Department of Health and Hospitals shall be referred to the Health Standards Section Special Consultant.

2. If it has been determined that complaints involving alleged violations of any criminal law pertaining to a nursing facility are valid, the investigating office of DHH shall furnish copies of the complaints for further investigation to both the Medicaid Fraud Control Unit of the Louisiana Department of Justice and the local office of the District Attorney.

G. Investigation Procedure. The protocol to be used when investigating complaints is as follows.

1. The investigator(s) must identify him/herself to the administrator or in the absence of the administrator, to the person designated to be in charge at the time.

2. At the entrance conference, the nature of the complaint will be given and anonymity of the complaint respected if requested.

3. If, during the investigation, deficiencies are found which were not cited in the complaint, these shall be written in a separate memo and addressed in a separate letter to the administrator.

4. At the conclusion of the investigation, an exit conference should be held with the administrator and any other personnel the Administrator may want present. The valid and non-valid findings should be shared with those present at the conference. Appropriate recommendations can be made at this time.

a. Prompt Investigation of Cases Determined to be Immediate Jeoparty. A complaint of abuse will be referred by DHH to the Regional Office immediately upon receipt and staff from the Regional office will investigate the complaint within five days. The facility also has a

responsibility to thoroughly investigate and take measures to prevent further abuse.

i. The disposition of other complaints will be determined according to the content and urgency of the complaint. When possible, referrals will be made to other agencies or Departments which can address the complaint and respond to the complainant.

b. Investigation Tasks. If the complaint involves abuse and/or neglect, an immediate investigation shall include the following:

i. interviewing the resident, if possible, and other persons who may have pertinent information;

ii. determining the nature of the abuse and/or neglect;

iii. determining the extent of the abuse and/or neglect;

iv. determining the cause of the abuse and/or neglect, if known; and

NOTE: A copy of the investigation report shall be submitted to the District Attorney.

v. if the complaint involves dietary, housekeeping, general care, residents' rights, patient funds, etc., the investigation shall include the following (as applicable to the situation);

(a). review of the medical record(s);

(b). interview (observation) of the resident and other residents;

(c). interview pertinent staff members;

(d). interview complainant, family, visitors, doctor as necessary for the particular complaint;

(e). perform a drug pass observation; and

(f). perform dining and eating assistance observation.

c. Manner of Reporting

i. If the complaint is not valid, a typed report of the investigation, listing each complaint and the findings will be sent to the Special Consultant of the Bureau of Health Services Financing-Health Standards Section.

ii. If any portion of the complaint is found to be valid, a 2567 Form shall be filled out, on site if possible, identifying the ID Prefix Tag, the deficiency, and the Administrator's Plan of Correction and completion date. This form should accompany the written report of the findings of this complaint. If the administrator is not able to provide a Plan of Correction on site, the portion of Form 2567 to be filled in by the investigator should be completed and sent with the written report to the Special Consultant, who will be responsible for obtaining the Plan of Correction.

d. Notice of Investigation to the Facility. The nature of the complaint shall be given to the nursing facility no earlier than when the on-site investigation begins at the facility.

e. Confidentiality. In order to protect the confidentiality of complainants, residents shall not be identified to the nursing facility unless they consent to the disclosure.

NOTE: If disclosure becomes essential to the investigation, the complainant shall be given the opportunity to withdraw the complaint.

f. Disposition of Complaints. If, after investigation, the complaint is found to be valid, the Department of Health and Hospitals shall notify the administrator who will provide an acceptable plan of correction.

i. If it is determined that a situation presents a threat to the health and safety of the resident, the nursing facility shall be required to take immediate corrective action. The Department of Health and Hospitals will certify non-compliance and initiate termination, non-renewal, or intermediate sanctions. HCFA-462 (Adverse Action Extract) and HCFA-562 (Medicare/Medicaid Complaint Form) will be completed.

ii. In all other instances of violation, an expeditious correction, not to exceed 90 days, shall be required.If a Condition of Participation in a Skilled Nursing Facility or a Program Standard in a Nursing Facility is not met and determined that the provider has a limited capacity to provide adequate care and/or services, or provider is unable or unwilling, the Department of Health and Hospitals will certify non-compliance and initiate termination, non-renewal, or intermediate sanctions.

iii. In cases of abuse and/or neglect, referral for appropriate corrective action shall be made to the Medicaid Fraud Control Unit of the Attorney General's Office.

g. Unsubstantiated Complaint. If, after investigation, the complaint is determined to be unsubstantiated, DHH shall notify the complainant and the facility of this fact.

h. Repeat Violations. When violations continue to exist after the corrective action was taken, the Department of Health and Hospitals may take appropriate action against the nursing facility to include decertification or revocation of its license.

i. Follow-up Activity. Deficiencies will be scheduled for follow-up visits as soon as possible after the approved provider completion date on appropriate documents.

j. Narrative Report Content. The narrative report content is as follows:

i. date of investigation;

ii. what was done (tour, drug pass, etc.);

iii. who was interviewed;

iv. identify each aspect of the complaint, conclusions and state whether valid, not valid, or unable to validate.

k. Results of Complaint Investigation. These results will be considered in conducting annual surveys and making certification decisions. Staff will read the complaint file prior to the annual survey.

l. Fair Hearing. Complainants who are dissatisfied with any action taken by the Department of Health and Hospitals in response to their complaints may request a fair hearing to review the action in accordance with Subchapter §10161. A request for a fair hearing shall be submitted in writing to the Secretary, DHH, P.O. Box 629, Baton Rouge, LA 70821-0629.

m. Retaliation by Nursing Facility. Facilities are prohibited from taking retaliatory action against complainants. Persons aware of retaliatory action or threats in this regard should contact the Department of Health and Hospitals.

n. Notification of the Complaint Procedure. The Department of Health and Hospitals "Blue Book" which has the complaint procedure shall be posted in each nursing facility in a conspicuous place where residents gather. This "Blue Book", known as "Nursing Home Care in Louisiana", was developed for the public by the Department of Health and Hospitals. This booklet shall be distributed based upon availability by all licensed nursing facilities to all current residents and/or their legal representatives or sponsors and to all new residents and/or their legal representative or sponsors on the date of their admissions.

o. Reporting of Incidents. For each resident who is involved in an accident or incident, an incident report shall be completed including the name, date, time, details or accident or incident, circumstances under which it occurred, witnesses and action taken. Incident reports are an administrative tool to pinpoint problem areas and shall result in corrective action, where representatives of the U.S. Department of Health and Human Services and DHH upon request and without prior notice.

i. Incidents or accidents involving residents shall be noted in the nurse's notes and these records should contain all pertinent medical information.

(a). The examples listed below are not all inclusive, but are presented to serve as a guideline to assist those facility employees responsible for reporting incident reports.

(i). Suspicious Death. Death of a resident or on-duty employee when there is suspicion of death other than by natural causes.

(ii). Abuse and/or Neglect. All incidents or allegations of abuse and/or neglect.

(iii). Runaways. Runaways considered to be dangerous to self or others.

(iv). Law Enforcement Involvement. Arrest, incarceration, or other serious involvement of residents with law enforcement authorities.

(v). Mass Transfer. The voluntary closing of a facility or involuntary mass transfer of residents from a facility.

(vi). Violence. Riot or other extreme violence.

(vii). Disasters. Explosions, bombings, serious fires.

(viii).Accidents/Injuries. Severe accidents or serious injury involving residents or on-duty employees caused by residents such as life threatening or possible permanent and/or causing lasting damage.

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Subchapter L. Sanctions and Appeal Procedures

§10167. General Provisions

A. Authority and Scope. Any person or entity found to be in violation of any provision of R.S. 40:2009.1 through 40:2009.11 or any other state or federal statute, regulation, or any Department of Health and Hospitals' rule adopted pursuant to the Administrative Procedure Act governing the administration of nursing facility care may be sanctioned by one or more of the following remedies:

1. plan of correction;
2. monitoring;
3. special staffing requirements;
4. civil money penalties (fines);
5. denial of payment for new admissions;
6. withholding of vendor payments;
7. temporary management;
8. termination of certification; and
9. revocation of license;

NOTE: The Secretary or his designee may impose any of the above cited sanctions separately or in combination. In addition to the foregoing administrative remedies, the Secretary may have recourse to any judicial remedies provided by law;

a. Considerations. The secretary shall impose the sanction(s) which will bring the facility into compliance in the most efficient and effective manner with the care and well-being of the residents being the paramount consideration. The secretary's decision shall be based on an assessment of some or all of the following factors:

i. whether the violations pose an immediate threat to the health or safety of the residents;

ii. the duration of the violations;

iii. whether the violation (or one that is substantially similar) has previously occurred during the last three consecutive surveys;

iv. the facility's history of compliance during the last three consecutive surveys;

v. what sanction is most likely to cause the facility to come into compliance in the shortest amount of time;

vi. the severity of the violation if it does not pose an immediate threat to health or safety;

vii. the logistical feasibility of implementing the sanction;

viii. the "good faith" exercised by the facility in attempting to stay in compliance;

ix. the financial benefit to the facility of committing or continuing the violation; and

x. such other factors as the secretary deems appropriate.

b. Repeated Findings of Substandard Care. Where the facility has been found to have provided substandard quality of care on three consecutive standard surveys, the secretary shall (regardless of what other remedies are provided):

i. deny payment under the state plan with respect to any individual admitted to the nursing facility involved after notice to the public and to the facility as may be provided for by law;

ii. monitor the facility on site, until the facility has demonstrated, to the satisfaction of the Department, that it is in compliance with all requirements and that it will remain in compliance with such requirements;

c. Immediate Jeopardy. Where the department determines that a facility no longer meets the requirements of certification and further finds that the facility's deficiencies immediately jeopardize the health or safety of its residents, the department shall:

i. take immediate action to remove the jeopardy and correct the deficiencies through the appointment of temporary management; or

ii. terminate the facility's participation under the state plan and may provide, in addition, any other remedies the department deems appropriate.

d. Non-immediate Jeopardy. If the facility's deficiencies do not immediately jeopardize the health or safety of its residents, the department may:

i. terminate the facility's participation under the state plan;

ii. provide for one or more of the remedies described in Authority and Scope of this Subchapter §10167; or

iii. do both.

B. Notice and Appeal Procedure

1. Unless otherwise indicated, any sanction may be administratively appealed in the manner described as long as the appeal is timely filed following notice of the department's decision.

2. The Health Standards Section will notify the Office of Elderly Affairs State Ombudsman of all adverse actions taken against nursing facilities. If adverse actions result in an appeal hearing, the representative of the Office of State Ombudsman will attend and offer testimony if knowledgeable about the situation.

3. Notice to Facility of Violation. When the Department of Health and Hospitals has reasonable cause to believe through an on-site survey, a complaint investigation, or other means that there exists or has existed a threat to the health, safety, welfare, or rights of a nursing facility resident, the department shall give notice of the violation(s) in the following manner.

a. The head of the survey team shall conduct an exit conference and give the facility administrator or his designee the preliminary finding of fact and the possible violations before leaving the facility.

b. The department shall follow the discussion with confirmed written notice given by certified mail or hand delivery to the facility administrator. The written notice of deficiencies shall be consistent with the unresolved findings delivered at the exit conference.

c. The written notice given by the department shall:

i. specify the violation(s);

ii. cite the legal authority which established such violation(s);

iii. cite any sanctions assessed for each violation;

iv. inform the administrator that the facility has ten days from receipt of notice sent by certified mail or hand delivery within which to request a reconsideration of the proposed agency action;

v. inform the administrator of the facility that the consequences of failing to timely request an administrative appeal will be that the departmental determination is final and no further administrative or judicial review may be had; and

vi. inform the administrator of the facility if the Department has elected to regard the violation(s) as repeat violation(s) or as continuing violation(s) and the manner in which sanctions will be imposed.

d. The Department of Health and Hospitals shall have the authority to determine whether a violation is a repeat violation and shall inform the facility in its notice of that determination. Violations may be considered repeat violations by the Department of Health and Hospitals if the following conditions are found to exist.

i. Where the Department of Health and Hospitals has established the existence of a violation as of a particular

date and the violation is one that may be reasonably expected to continue until corrective action is taken, the department may elect to treat said continuing violation as a repeat violation subject to appropriate fines for each day following the date on which the initial violation is established, until such time as there is evidence establishing a date by which the violation was corrected.

ii. Where the Department of Health and Hospitals has established the existence of a violation and another violation occurs within 18 months which is the same or substantially similar to the previous violation, the subsequent violation and all other violations thereafter shall be considered repeat violations subject to fines and other Sanctions appropriate for repeat violations.

iii. If the facility does not request an administrative appeal in a timely manner or does not submit satisfactory evidence to rebut the department's findings of a violation, the secretary shall have the authority to enforce sanctions, as provided in these regulations. The Department of Health and Hospitals shall forward its findings to the facility by certified mail or hand delivery, and any sanctions imposed shall commence as of the date such determination is received by the facility. The department may institute all necessary civil court action to collect fines imposed and not timely appealed. No nursing facility may claim fines as reimbursable costs, nor increase charges to residents as a result of such fines. Interest shall begin to accrue at the current judicial rate on the day following the date on which any fines become due and payable.

iv. The facility may request an administrative reconsideration of the violation(s) within ten days of receipt of notice of the proposed agency action. This reconsideration shall be conducted by a designated official of the department who did not participate in the initial decision to impose the penalty. 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 facility submits to the department at the time of its request for reconsideration.
Correction of a violation shall not be a basis for reconsideration. A hearing shall not be held. Oral presentations can be made by Department spokesperson, facility spokesperson, and Elderly Affairs Representatives familiar with the facts and circumstances of the violation. The designated official shall have authority only to affirm the decision, to revoke the decision, to affirm in part and revoke in part, or to request additional information from either the department or the facility. The secretary or a designated official shall be without authority to waive any penalty or to compromise the dollar amount of any penalty unless part of the original decision is revoked. The official shall render a decision on the reconsideration within three days from the date of receipt of the facility's request.

e. If the facility requests an administrative appeal, such request shall:

i. state which violation(s) the facility contests and the specific reasons for disagreement; and

ii. be submitted to the Department of Health and Hospitals within 30 days of receipt of the secretary's decision on the final agency action by certified mail or hand delivery.

f. The administrative hearing shall be limited to those issues specifically contested and shall not include any claim or argument that the violation(s) have been corrected. Any violations not specifically contested shall become final, and sanctions shall be enforced at the expiration of the time for appeal. All violations/sanctions not contested shall become final at the expiration of the appeal request time period.

g. Administrative Appeal Process

i. Except as hereinafter provided, when an administrative appeal is requested in a timely and proper manner, the Department of Health and Hospitals shall provide an administrative hearing in accordance with the provisions of the Louisiana Administrative Procedure Act. Any party may appear and be heard at any proceeding described herein through an attorney at law or through a designated representative. A person appearing in a representative capacity shall file a written notice of appearance on behalf of the facility identifying himself by name, address, and telephone number, and identifying the party represented, and shall have a written authorization to appear on behalf of the facility.

ii. The administrative law judge conducting the hearing may require the prevailing of any motions by either party no later than the close of business on the third working day prior to the hearing.

iii. When the violation(s) jeopardize the health, safety, rights, or welfare of the facility's residents, the requested hearing shall be held within 14 days of the receipt of the request. The administrative law judge shall review all relevant evidence and make a final written determination within six days after the administrative hearing.

iv. In all other cases, the requested hearing shall be held within 30 days of the receipt of the request. The administrative law judge shall review all relevant evidence and make a final written determination within 15 days after the administrative hearing.

v. The administrative law judge may assess attorney's fees and costs against the facility if it is determined that the facility's appeal was frivolous.

vi. Although not specifically required for an administrative hearing, the Administrative law judge may schedule a preliminary conference.

h. The purposes of the preliminary conference, if scheduled, include but are not limited to the following:

i. clarification, formulation and simplification of issue(s);

ii. resolution of matters in controversy;

iii. exchange of documents and information;

iv. stipulations of fact so as to avoid unnecessary introduction of evidence at the formal review;

v. the identification of witnesses; and

vi. such other matters as may aid disposition of the issues.

(a). When the administrative law judge schedules a preliminary conference, (s)he shall notify all parties in writing. The notice shall direct any parties and their attorneys to appear at a specified date, time, and place.

(b). Where the preliminary conference resolves all or some matters in controversy, a summary of the findings agreed to at the conference shall be provided by the administrative law judge. Where the preliminary conference does not resolve all matters in controversy, an administrative hearing shall be scheduled on those matters still in controversy. The hearing shall be scheduled to conform to these procedures on those matters still in controversy.

(c). When an administrative hearing is scheduled, the administrative law judge shall notify the facility and/or its attorney and the agency representative in writing of the date, time, and place of the hearing. Notice shall be mailed not less than 10 calendar days before the scheduled date of the hearing.

h. Hearing Procedures

i. The administrative appeal hearing shall be conducted by an administrative law judge from the Appeals Section.

ii. Testimony shall be taken only on oath, affirmation, or penalty of perjury.

iii. Each party shall have the right to call and examine parties and witnesses, to introduce exhibits, to question opposing witnesses and parties on any matter relevant to the issue even though the matter was not covered in the direct examination, to impeach any witness regardless of which party first called him to testify, and to rebut the evidence against him.

iv. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in civil or criminal actions. Documentary evidence may be received in the form of copies or excerpts.

v. The administrative law judge may question any party or witness and may admit any relevant and material evidence.

vi. The administrative law judge shall control the taking of evidence in a manner best suited to ascertain the facts and safeguard the rights of the parties. Prior to taking evidence, the administrative law judge shall explain the issues and the order in which evidence will be received.

vii. A party has the burden of proving whatever facts it must establish to sustain its position.

viii. The burden of producing evidence as to a particular fact is on the party against whom a finding on that fact would be required in the absence of further evidence.

ix. Each party shall arrange for the presence of their witnesses at the hearing.

x. A subpoena to compel the attendance of a witness may be issued by the Administrative law judge upon written request by a party and showing of the need therefore. A subpoena may be issued by the administrative law judge on his own motion.

xi. An application for subpoena duces tecum for the production by a witness of books, papers, correspondence, memoranda, or other records shall be made in writing to the administrative law judge, giving the name and address of the person or entity upon whom the subpoena is to be served. The application shall precisely describe the material that is desired to be produced and shall state the materiality thereof to the issue involved in the proceeding. It shall also include a statement, that to the best of the applicant's knowledge, the witness has such items in his possession or under his control.

xii. The administrative law judge may continue the matter when such continuance will not jeopardize the health, safety, rights, or welfare of the facility's residents.

xiii. The administrative law judge may continue a hearing to another time or place, or order a further hearing on his own motion or upon showing of good cause, at the request of any party, provided that the time limits by the Administrative Appeal Process in this subchapter §10167 are met.

xiv. Where the administrative law judge determines that additional evidence is necessary for the proper determination of the case, he may at his discretion:

(a). continue the hearing to a later date and order the party to produce additional evidence; or

(b). close the hearing and hold the record open in order to permit the introduction of additional documentary evidence. Any evidence so submitted shall be made available to both parties and each party shall have the opportunity for rebuttal.

xv. Written notice of the time and place of a continued or further hearing shall be given except that when a continuance of further hearing is ordered during a hearing, oral notice of the time and place of the hearing may be given to each party present at the hearing.

xvi. A sound recording of the hearing shall be made. A transcript will be prepared and reproduced at the request of a party to the hearing provided he bears the cost of the copy of the transcript.

xvii. At the conclusion of the hearing, the administrative law judge shall take the matter under submission. The administrative law judge shall prepare a

written proposed decision to the Secretary of the Department of Health and Hospitals which will contain findings of fact, a determination of the issues presented, a citation of applicable policy and regulations, and an order.

xviii. The administrative law judge shall make specific written findings as to each violation that was contested by the facility. The administrative law judge shall have authority to affirm, reverse, or modify the findings or penalties of the department. The administrative law judge shall transmit such findings by certified mail or hand delivery to the facility at the last known address within time periods stated above in Administrative Appeal Process and by regular mail or hand delivery to the Department and other affected parties. Any civil fines assessed shall commence as of the date findings are received by the facility. Interest on the amount of the fines assessed shall begin accruing on the eleventh day following commencement of the fines at the then current rate of judicial interest.

xix. If a facility representative fails to appear at a hearing, a decision may be issued by the administrative law judge dismissing the appeal hearing and making the departmental findings final. A copy of the decision shall be mailed to each party.

x. Any dismissal may be rescinded upon order of the administrative law judge if the facility's representative makes written application within 10 calendar days after mailing of the dismissal, provides evidence of good cause for his failure to appear at the hearing, and no delay beyond the time limits as indicated in this Subchapter, §10167 under Administrative Appeal Process results.

i. Judicial Review

i. If the results of the administrative hearings are adverse to the facility, the facility may request a judicial review of such matters to the Nineteenth Judicial District Court within 15 days of receipt of such findings. Such appeal shall be suspensive.

ii. The facility shall furnish with the appeal, a bond in the minimum amount of one and one-half times the amount of the fine imposed by the Department of Health and Hospitals. The bond furnished shall provide in substance that it is furnished as security that the facility will prosecute its appeal, that any judgment against it including court courts, will be paid or satisfied from the amount furnished, or that otherwise the surety is liable for the amount assessed against the facility.

iii. The appeal shall be heard in a summary proceeding.

iv. At the conclusion of the judicial review, any party aggrieved by the decision may seek further appeals as authorized by law.

C. Description of Sanctions

1. Monitoring On-Site. In the case of a nursing facility which, on three consecutive standard surveys conducted, has been found to have provided substandard quality of care, the state shall (regardless of what other remedies are provided):

a. impose the denial of payment for new admissions; and

b. monitor the facility until the facility has demonstrated to the satisfaction of the state, that it is in compliance with the requirements and that it will remain in compliance with such requirements. The department shall monitor, on-site, on a regular, as needed basis, a nursing facility's compliance with the requirements if:

i. the facility has been found not to be in compliance with such requirements and is in the process of correcting deficiencies to achieve such compliance;

ii. the facility was previously found not to be in compliance with such requirements, has corrected deficiencies to achieve such compliance, and verification of continued compliance is indicated; or

iii. she state has reason to question the compliance of the facility with such requirements.

c. The department may monitor conditions while improvements are being made or while the facility is being closed. Monitoring can include:

i. periodic unannounced site visits by a surveyor during the period of the day where care is most compromised (e.g. during the medication administration or during the meal service); or

ii. on-site full time monitoring by surveyors on shifts on 8-12 hours to observe all phases of operation of the facility.

d. The state may maintain and utilize a specialized team (including an attorney, an auditor, and appropriate health care professionals) for the purpose of identifying, surveying, gathering and preserving evidence, and carrying out appropriate enforcement actions against chronically substandard nursing facilities.

NOTE: The notice and appeal procedures previously described in this Subchapter, §10167 apply.

2. Specific Staffing Requirements. When there is a breakdown in the care and services at a facility and the efforts of the facility have not been successful in correcting these deficiencies, the department may require special staffing on the part of the facility paid for by the facility. This could include (though it is not limited to) a consultant on resident assessments or care planning, an additional licensed nurse to provide treatments, a consultant dietician, a consultant pharmacist, or medical records practitioner. Any special staffing shall be in addition to the staff already hired. The special staffing shall be time limited and shall be clearly outlined in a letter from the secretary or the designee.

a. The notice and appeal procedures described previously in this Subchapter, §10167 shall apply.

3. Civil Money Penalties (Fines). The following listed civil fines pertaining to classified violations may be assessed by the secretary against nursing facilities. In the case of Class A violations, the following civil fines shall be assessed. In the cases of Class B, C, D, or E violations, the

Secretary, in his discretion, may elect to assess the following civil fines or may allow a specified period of time for correction of said violation. For Class D and E violations, the facility will be given notice of the fine at the time of the first violation and may be given an opportunity to demonstrate compliance before the fine becomes final. If compliance is demonstrated on the follow-up visit, payment of fine may be waived. In all instances the violation is counted and recorded. If compliance is not demonstrated at the next visit, the penalty for a repeat violation will be assessed. No facility shall be penalized because of a physician's or consultant's non-performance beyond the facility's control or if the violation is beyond the facility's control, if the situation and the efforts to correct it are clearly documented. It is not the intent that every violation found on a survey, inspection, or related visit should be accompanied by an administrative penalty.

a. Class A Violations. Class A violations are subject to a civil fine which shall not exceed $2,500.00 for the first violation. A second Class A violation occurring within an 18 month period from the first violation shall not exceed $5,000.00 per day. The third Class A violation shall result in proceedings being commenced for termination of the facility's Medicaid agreement and may result in proceedings being commenced for revocation of licensure of the facility.

b. Class B Violations. Class B violations are subject to a civil fine which shall not exceed $1,500.00 for the first violation. A second Class B violation occurring within an 18 month period from the first violation shall not exceed $3,000.00 per day. The third Class B violation shall result in proceedings being commenced for termination of the facility's Medicaid agreement and may result in proceedings being commenced for revocation of licensure of the facility.

c. Class C Violations. Class C violations are subject to a civil fine which shall not exceed $1,000.00 for the first violation. A second Class C violation occurring within an 18 month period from the first violation shall not exceed $2,000.00 per day. The third Class C violation shall result in proceedings being commenced for termination of the facility's Medicaid agreement and may result in proceedings being commenced for revocation of licensure of the facility.

d. Class D Violations. Class D violations are subject to a civil fine which shall not exceed $100 for the first violation. Each subsequent Class D violation within an 18 month period from the first violation shall not exceed $250 per day.

e. Class E Violations. Class E violations are subject to a civil fine which shall not exceed $500 for the first violation. Each subsequent Class E violation occurring within an 18 month period from the first violation shall not exceed $100 per day.

i. The total amount of fines assessed for violations determined in any one month shall not exceed $5,000.00, except that the aggregate fines assessed for Class A or B violations shall not exceed $10,000.00 in any one month.

f. Factors in Assessment of Civil Fines. In determining whether a civil fine is to be assessed and in affixing the amount of the fine to be imposed, the secretary shall consider:

i. the gravity of the violation including the probability that death or serious physical harm to a resident will result or has resulted;

ii. the severity and scope of the actual or potential harm;

iii. the extent to which the provisions of the applicable statutes or regulations were violated;

iv. the "good faith" exercised by the licensee. Indications of good faith include, but are not limited to:

(a). prior accomplishments manifesting the licensee's desire to comply with requirements;

(b). efforts to correct; and

(c). any other mitigating factors in favor of the licensee;

v. any relevant previous violations committed by the licensee.

vi. the financial benefit to the licensee of committing of continuing the violation;

vii. approved waivers.

g. Right to Assess Civil Fines Not Merged In Other Remedies. Assessment of a civil fine provided by this section shall not affect the right of the Department of Health and Hospitals to take such other action as may be authorized by law or regulation.

D. Classes of Violations Defined

1. Class A Violations. Those violations which create a condition or occurrence relating to the operation and maintenance of a nursing facility which result in death or serious harm to a resident.

2. The following examples of Class A violations are provided for illustrative purposes only and are subject to the conditions outlined in Subchapter L, Sanctions.

a. Death of a Resident. Any condition or occurrence relating to the operation of a nursing facility in which the conduct, act, or omission of a person or actor purposely, knowingly, or negligently results in the death of a resident shall be a Class A violation.

b. Serious Physical Harm to a Resident. Any condition or occurrence relating to the operation of a nursing facility in which the conduct, act, or omission of a person or actor purposely, knowingly, or negligently results in serious physical harm to a resident shall be a Class A violation.

NOTE: The above examples of Class A violations are provided for illustrative purposes only.

3. Class B Violations. Those violations which create a condition or occurrence relating to the operation and maintenance of a nursing facility which create a substantial

probability that death or serious physical harm to a resident will result from the violation.

4. The following examples of Class B violations are provided for illustrative purposes only and are subject to the conditions outlined in Subchapter L, Sanctions.

5. The following conduct, acts, or omissions, which do not result in death or serious physical harm but which create a substantial probability that death or serious physical harm to a resident will result therefrom, are conditions or occurrences relating to the operation of a nursing facility and are Class B violations:

a. Nursing Techniques. A Class B violation shall exist when good nursing practice is not exercised and this results in the following occurrences:

i. medications or treatments are improperly administered or withheld by nursing personnel;

ii. there is a failure to adequately and appropriately feed residents who are unable to feed themselves or there is use of specialized feeding equipment or substances which are outdated, not protected from contamination, or incorrectly used;

iii. there is a failure to change or irrigate catheters as ordered by a physician or there is use of irrigation sets or solutions which are outdated or not protected from contamination;

iv. there is a failure to obtain physician orders for the use, type, and duration of restraints or physical restraints are improperly applied or facility personnel fail to check and release restraint as specified in regulations;

v. staff knowingly fails to answer call lights;

vi. there is a failure to turn or reposition as ordered by a physician or as specified in regulations;

vii. there is a failure to provide rehabilitative nursing as ordered by a physician or as specified in regulations.

b. Poisonous Substances. A Class B violation shall exist when a facility fails to provide proper storage of poisonous substances.

c. Falls by Residents. A Class B violation shall exist when a facility fails to maintain required direct care staffing, follow physician's orders, provide a safe environment, or address a history of falls on a resident's care plan, and this failure directly causes a fall by a resident. (Examples: Equipment not properly maintained or a fall due to personnel not responding to a resident's request for assistance.)

d. Assaults. A Class B violation shall exist when a facility fails to maintain required direct care staffing, adequately trained staff, or take appropriate measures when it is known that a resident is combative or assaultive with other residents, and this failure causes an assault upon a resident of the facility by another resident. A Class B violation shall also exist when a facility fails to perform adequate screening of personnel and this failure causes an assault upon a resident by an employee of the facility.

e. Permanent Injury to a Resident. A Class B violation shall exist when facility personnel improperly apply physical restraints as directed by physician's orders or regulations and this failure causes permanent injury to a resident.

f. Nosocomial Infection. A Class B violation shall exist when a facility does not follow or meet nosocomial infection control standards as outlined by regulations or as ordered by the physician.

g. Medical Services. A Class B violation shall exist when a facility fails to secure proper medical assistance or orders from a physician and this creates the probability of death or serious harm of a resident.

h. Decubitus Ulcers. A Class B violation shall exist when a facility does not take decubitus ulcer measures as ordered by the physician or facility personnel fail to notify the physician of the existence or change in the condition of such ulcers and such failure creates a probability of death or serious physical harm of a resident.

i. Treatments. A Class B violation shall exist when facility personnel performs treatment(s) contrary to a physician's order or fail to perform such treatments and such treatment creates the probability of death or serious physical harm of a resident.

j. Medications. A Class B violation shall exist when facility personnel knowingly withhold medication from a resident as ordered by a physician and such withholding of medication(s) creates the probability of death or serious injury of a resident, or facility personnel fails to order and/or stock medication(s) prescribed by the physician and the failure to order and/or stock medication(s) creates a probability of death or serious harm of a resident.

k. Elopement. A Class B violation shall exist when a facility does not provide reasonable supervision of residents to prevent a resident from wandering away from the facility and such failure creates the probability of death or serious harm to a resident, or a facility does not provide adequate measures to ensure that residents with an elopement history do not wander away from the facility. (Examples of preventive measures include but are not limited to documentation that an elopement history has been discussed with the family or other caretaker of the resident, alarms have been placed on exit doors, personnel have been trained to make additional effort to watch the resident with such history, and the physician of such resident has been made aware of such history.)

l. Failure to Provide Heating or Air Conditioning. A Class B violation shall exist when a facility fails to reasonably maintain its heating and air conditioning system as required by regulation. Isolated incidents of breakdown or power failure shall not be considered Class B violations under this section.

m. Natural Disaster/Fire. A Class B violation shall exist when a facility does not train staff in fire/disaster procedures as required by regulations or when staffing requirements are not met.

n. Life Safety Code System. A Class B violation shall exist when a facility fails to maintain the required life safety code system. Isolated incidents of breakdown shall not be considered a Class B violation if the facility has immediately notified the Health Standards Section upon discovery of the problem and has taken all necessary measures to correct the problem.

o. Nursing Equipment/Supplies. A Class B violation shall exist if equipment and supplies to care for a resident as ordered by a physician are not provided, or if the facility does not have sufficient equipment and supplies for residents as specified by regulation and these conditions create a probability of death or serious harm to a resident.

p. Call System. A Class B violation shall exist when a facility fails to maintain a resident call system or the call system is not functioning for a period of more than 24 hours. If call system cords are not kept within reach of residents then it will be determined that the facility has failed to maintain a resident call system and this failure creates a probability of death or serious physical harm to a resident.

NOTE: The above examples of Class B violations are provided for illustrative purposes only.

6. Class C Violations - The following conduct, acts, or omissions which do not result in death or serious physical harm to a resident or the substantial probability thereof but create a condition or occurrence relating to the operation and maintenance of a nursing home facility that create a potential for harm by directly threatening the health, safety, rights or welfare of a resident are Class C violations.

NOTE: The following examples of Class C violations are provided for illustrative purposes only and are subject to the conditions outlined in Subchapter L.

a. Nursing Techniques. A Class C violation shall exist when good nursing practice is not exercised and this results in the following occurrences:

i. medications or treatments are improperly administered or withheld by nursing personnel;

ii. there is a failure to adequately and appropriately feed residents who are unable to feed themselves or there is use of specialized feeding equipment and substances which are outdated, not protected from contamination or incorrectly used;

iii. there is a failure to change or irrigate catheters as ordered by a physician or there is use of irrigation sets and solutions which are outdated or not protected from contamination;

iv. there is a failure to obtain physician orders for the use, type, and duration of restraints, or physical restraints are improperly applied, or facility personnel fail to check and release the restraint as specified in regulations;

v. staff knowingly fails to answer call lights;

vi.there is a failure to turn or reposition residents as ordered by a physician or as specified in regulations; and

vii. there is a failure to provide rehabilitative nursing as ordered by a physician or as specified in regulations.

b. Poisonous Substances. A Class C violation shall exist when a facility fails to provide proper storage of poisonous substances and this failure threatens the health, safety, rights or welfare of a resident.

c. Falls by Residents. A Class C violation shall exist when it is determined that falls may occur in a facility as a result of the facility's failure to maintain required direct care staffing or a safe environment (including adequate training of staff) as set forth in regulation and this failure threatens the health, safety, rights, or welfare of a resident.

d. Assaults. A Class C violation shall exist when a facility fails to maintain required direct care staffing or measures are not taken when it is known that a resident is combative and assaultive with other residents and this lack threatens the health, welfare, rights, or safety of a resident.

e. Improper Use of Restraints. A Class C violation shall exist when facility personnel apply physical restraints contrary to published regulations or fail to check and release such restraints as directed by physician's order or regulations and such failure threatens the health, safety, rights, or welfare of a resident.

f. Medical Services. A Class C violation shall exist when a facility fails to secure proper medical assistance or orders from a physician and this failure threatens the health, safety, rights or welfare of a resident.

g. Decubitus Ulcers. A Class C violation shall exist when a facility does not take decubitus ulcer measures as ordered by the physician and this failure threatens the health, safety, rights or welfare of a resident, or facility personnel fail to notify the physician of such ulcers or change in a resident's condition with regard to decubitus ulcers and this failure threatens the health, safety, rights or welfare of a resident.

h. Treatments. A Class C violation shall exist when facility personnel perform treatments contrary to physician's order or fail to perform such treatments and such treatment threatens the health, safety, rights, or welfare of a resident.

i. Medications. A Class C violation shall exist when facility personnel withhold physician ordered medication(s) from a resident and such withholding threatens the health, safety, rights, or welfare of a resident, or facility personnel fail to order or stock medication(s) prescribed by the physician and this failure threatens the health, safety, rights, or welfare of a resident.

j. Elopement. A Class C violation shall exist when a facility does not provide reasonable supervision of residents to prevent a resident from wandering away from the facility and such failure threatens the health, safety, rights, or welfare of a resident, or a facility does not provide adequate measures to ensure that residents with a history of

elopement do not wander away from the facility and such failure threatens the health, safety, rights, or welfare of a resident.

k. Food on Hand. A Class C violation shall exist when there is an insufficient amount of food on hand in the facility to meet the menus for the next three-day period and this failure threatens the health, safety, rights, or welfare of a resident.

l. Nursing Equipment/Supplies. A Class C violation shall exist if equipment and supplies to care for a resident as ordered by a physician are not provided, or if the facility does not have sufficient equipment and supplies for residents as specified by regulation and these conditions threaten the health, safety, rights, or welfare of a resident.

m. Call System. A Class C violation shall exist when a facility fails to maintain a resident call system or the call system is not functioning for a period of 24 hours. If call system cords are not kept within reach of residents then it will be determined that the facility has failed to maintain a resident call system and this failure threatens the health, safety, rights, or welfare of a resident.

n. Heating and Air Conditioning. A Class C violation shall exist when a facility fails to maintain its heating and air conditioning systems as required by regulation and such failure threatens the health, safety, rights, or welfare of a resident. Isolated incidents of breakdown or power failure shall not be considered a Class C violation under this Section.

o. Natural Disaster/Fire. A Class C violation shall exist when a facility does not train staff in fire/disaster procedures as required by regulations or when staffing requirements are not met and this failure threatens the health, safety, rights, or welfare of a resident.

p. Life Safety Code System. A Class C violation shall exist when a facility fails to maintain the required life safety systems and this threatens the health, safety, rights or welfare of a resident. Isolated incidents of breakdown shall not be considered a Class C violation if the facility has immediately notified the Health Standards Section upon discovery of the problem and has taken all necessary measures to correct the problem.

r. Dietary Allowance. A Class C violation shall exist when it is determined that the minimum dietary needs of a resident are not being met as ordered by the physician.

s. Resident Rights. A Class C violation shall exist when facility personnel fails to inform a resident of his Resident Rights as outlined in regulation, or facility personnel fail to allow a resident to honor or exercise any of his rights as outlined in regulation or statute.

t. Sanitation. A Class C violation shall exist when it is determined that regulations relating to sanitation are not met.

u. Administrator. A Class C violation shall exist when it is determined that a facility does not have a licensed administrator for 30 or more consecutive days as required by regulation.

v. Director of Nurses. A Class C violation shall exist when it is determined that a facility does not have a director of nurses (DON) as required by regulation for 30 or more consecutive days unless a waiver has been granted by the department.

w. Notice of Staff Vacancy. A Class C violation shall exist when it is determined that a facility does not have a licensed administrator or a Director of Nurses and has not notified the bureau within ten days as required by regulation.

NOTE: The examples above of Class C violations are provided for illustrative purposes only.

7. Class D Violations. Those violations which are related to administrative and reporting requirements that do not directly threaten the health, safety, rights, or welfare of a resident.

NOTE: The following examples of Class D violations are provided for illustrative purposes only and are subject to the conditions outlined in subchapter L.

a. Overbedding. A Class D violation shall exist when a facility is found to exceed its licensed bed capacity.

b. False Reporting. A Class D violation shall exist when it has been determined that a report, physician's orders, nurses' notes, patient account records, staffing records, or other documents or records which the facility is required to maintain have been intentionally falsified.

c. Resident Trust Funds. A Class D violation shall exist when it is determined that the facility's records reflect that resident trust funds have been misappropriated by facility personnel or if a resident has been charged for items which the facility must provide at no cost to the resident.

d. Denial of Access of Facility. A Class D violation shall exist when it is determined that personnel from the Louisiana Department of Health and Hospitals, the United States Department of Health and Human Services, or personnel of any other agency authorized to have access to any nursing facility have been denied access to the facility or to any facility document record.

e. Reporting of Unusual Occurrences/ Accidents .A Class D violation shall exist when it has been determined that a facility did not report any unusual occurrences or accidents in a timely manner as mandated by regulation.

f. Residents' Council. A Class D violation shall exist when a facility fails to allow a resident access to an established Residents' Council if one exists.

NOTE: The examples above of Class D violations are provided for illustrative purposes only.

8. Class E Violations. Class E violations are defined as the failure of any nursing facility to submit a statistical or financial report in a timely manner as required by regulations. The failure to timely submit a statistical or financial report shall be considered a separate Class E violation during any month or part thereof in non-compliance.

NOTE: In addition to any civil fine which may be imposed, the director is authorized after the first month of a Class E violation to withhold any further reimbursement to the facility until the statistical or financial report is received by the Bureau of Health Services Financing.

E. Collection of Civil Fines Assessed. Civil fines assessed shall be final if:

1. no timely or proper appeal was requested;

2. the facility admits the violations and agrees to pay; and

3. the administrative hearing is concluded with findings of violations and time for seeking judicial review has expired.

a. When civil fines become final, they shall be paid in full within ten days of their commencement unless the department allows a payment schedule in light of a documented financial hardship. Such documentation shall be submitted within the ten-day period.

b. If payment of assessed civil fines is not received or security not posted within ten days after they are deemed final, the Department of Health and Hospitals shall deduct the full amount plus interest from money otherwise due to the facility as Medicaid reimbursement in its next (quarterly or monthly) payment.

c. No nursing facility may claim imposed fines as reimbursable costs, nor increase charges to residents as a result of such fines. Any audits performed by the Department of Health and Hospitals shall monitor this prohibition.

F. Denial of Medicaid Payments For All New Admissions

1. Mandatory Denial. In the case of a nursing facility which no longer meets the requirements, the state shall, regardless of what other remedies are provided:

a. impose the denial of payment; and

b. monitor the facility;

i. denial of payment applies to any individual admitted to the nursing facility involved after such notice to the public and to the facility as may be provided for by the state.

2. Agency Procedures. Before denying payments for new admissions, the agency must comply with the following requirements:

a. Provide the facility up to 60 days to correct the cited deficiencies and comply with the requirements (for SNFs and NFs);

b. If at the end of the specified period, the facility has not achieved compliance, give the facility notice of intent to deny payment for new admissions, and opportunity for an informal hearing.

NOTE: If the facility requests a hearing, see §10167, Notice and Appeal Procedure, of this Chapter.

3. Effect of Sanction on Status of Residents

a. The resident's status at the effective date of the denial of payment is the controlling factor in determining whether or not residents are subject to the denial of payment, if readmitted.

b. Residents admitted and discharged before the effective date of the denial of payment are considered new admissions, if readmitted, and are subject to the denial of payment.

c. Residents admitted on or after and discharged after the effective date of the denial of payment are considered new admissions if readmitted, and are subject to the denial of payment.

d. Residents admitted before and discharged on or after the effective date of the denial of payment are not considered new admissions if readmitted, and are not subject to the denial of payment.

e. Residents admitted before the effective date of the denial of payment and taking temporary leave, before, on, or after the effective date of the denial of payment are not considered new admissions upon return and thereafter, are not subject to the denial of payment.

f. Residents admitted on or after the effective date of the denial of payment and taking temporary leave, are not considered new admissions, but continue to be subject to the denial of payment.

4. Duration

a. The denial shall remain in effect until the Department determines the NF is in substantial compliance with requirements.

b. Notification to the provider and the appeal procedure is described in this chapter under Notice and Appeal Procedure.

c. Notification to the public shall be in the newspaper of widest circulation in the area.

G. Withholding of Vendor Payments. The Department of Health and Hospitals may withhold Medicaid vendor payments in whole or in part in the following situations, which are not all inclusive.

1. Incorrect/Inappropriate Charges. When the Department of Health and Hospitals determines that a Nursing Facility has incorrectly or inappropriately charged residents or responsible parties or there has been misapplication of resident funds, a sum not to exceed the inappropriate charges or misapplied funds may be withheld until the provider does the following:

a. makes restitution; and

b. submits documentation of such restitution to the Department of Health and Hospitals.

2. Inadequate Review/Revision of Plan of Care. When a Nursing Facility repeatedly fails to ensure that an adequate plan of care for a resident is reviewed and revised at least at

required intervals, the vendor payment may be withheld or recouped until such time as compliance is achieved.

3. Corrective Action on Complaints. When a facility fails to submit an adequate corrective plan in response to a complaint within seven days after receiving the complaint report, vendor payments may be withheld until an adequate corrective plan is received unless the time limit is extended by the Bureau of Health Services Financing or an administrative reconsideration or appeal is timely filed.

4. Unapproved Staffing Shortage. When a survey report indicates an unapproved staffing shortage, vendor payments may be withheld until such time as staffing is brought into compliance.

5. Corrective Action for Audit Findings. When a facility fails to submit corrective action in response to financial and compliance audit findings within 15 days after receiving the notification letter, vendor payments may be withheld until such time as compliance is achieved.

6. Request for Information. When a facility fails to respond satisfactorily to requests for information within 15 days after receiving the department's letter, vendor payments may be withheld until such time the information is received by the department.

7. Unauditable Records. When the department's auditors determine that a facility's records are unauditable, vendor payment shall be withheld as determined by the department.

8. Full Scope Audits. When the department's limited scope audit of the Residents' Personal Funds Account indicates a material number of transactions were not sufficiently supported, the department shall initiate a full scope audit of the account and the costs of the audit shall be withheld from the facility's monthly vendor payment.

NOTE: The Notice and Appeal procedures in this Subchapter apply.

H. Temporary Management

1. Regulatory Citation. Section 1919(h)(2)(A)(iii) of the Social Security Act requires the appointment of temporary management to oversee the operation of the facility and to assure the health and safety of the facility's residents.

2. Application. Immediately effective temporary management is appropriate while:

a. the facility is operating without a current Louisiana license;

b. the licensee has abandoned the facility;

c. the nursing facility is closing within 30 calendar days and the Department of Health and Hospitals has reasonable cause to believe that inadequate arrangements designed to minimize the adverse effects of transfer have been made to relocate its residents;

d. a condition or practice in a facility poses a serious and imminent threat to the health, safety, or welfare of the residents or presents a substantial probability that death or serious physical harm would result therefrom. In such instance the facility owner may request approval from the secretary to be put on 23-day fast track in lieu of temporary management. However, such request may only be granted when the Secretary determines that an adequate plan to protect the health, safety, and welfare of residents has been devised by the facility to prevent an imminent threat of harm to the facility's residents and when the secretary has provided satisfactory means for the department to monitor subsequent implementation of such corrective measures by the facility.

i. Appointment of a temporary manager based on one or more of the following grounds shall become effective only upon the later of the expiration of the period for seeking appeal or upon the entry of a final administrative determination by the Department of Health and Hospitals or a hearing officer.

(a). The nursing facility exhibits a consistent pattern of violating residents' rights established pursuant to Louisiana or federal laws or regulations.

(b). The nursing facility is experiencing financial difficulties that present a substantial probability the facility will be compelled to terminate operation.

3. Notice of Appointment of Temporary Manager. When the Secretary of the Department of Health and Hospitals determines that a nursing facility is in need of a temporary manager, he shall provide written notice which shall include:

a. the date the appointment shall take effect;

b. a statement setting forth grounds for the appointment;

c. The name of the person within the Department of Health and Hospitals who has the responsibility for responding to inquiries about the appointment;

d. The name of the person appointed temporary manager, if such designation has been made;

e. A statement explaining the procedure for requesting a hearing.

NOTE: Notice shall be delivered by hand or by certified mail to the owner and administrator of a nursing facility.

4. Powers and Duties of Temporary Manager. The licensee and administrator shall be divested of administration of the nursing facility in favor of the temporary manager from the effective date of appointment.

a. The temporary manager shall have the following powers and duties:

i. exercise those powers and perform those duties set out by the Department of Health and Hospitals in accordance with these and any other applicable provisions;

ii. operate the nursing facility in such a manner as to assure safety and adequate health care for the residents;

iii. take such action as is reasonably necessary to protect or conserve the assets or property of the facility for which the temporary manager is appointed, or the proceeds from any transfer thereof, and use them only in the performance of authorized powers and duties;

iv. use the building, fixtures, furnishings, and any accompanying consumable goods in the provision of care and services to residents and to any other persons receiving services from the nursing facility;

v. Collect payments for all goods and services provided to residents or others during the period of the temporary management at the same rate of payment charged by the owners at the time the temporary manager was appointed or at a fair and reasonable rate as otherwise approved by the Department of Health and Hospitals;

vi. correct or eliminate any deficiency in the structure or furnishings of the nursing facility which endanger the safety, health, or welfare or residents, provided the total cost of correction does not exceed $5,000. The Department of Health and Hospitals may order expenditures for this purpose in excess of $5,000 on application from the temporary manager after notice to the owner and an opportunity for informal hearing by the secretary or his designee to determine the reasonableness of the expenditures;

vii. let contracts and hire employees at rates reasonable in the community to carry out the powers and duties of the temporary management;

viii. honor all leases, mortgages, and secured transactions governing the building in which the nursing facility is located and all goods and fixtures in the building of which the temporary manager has taken possession, but only to the extent of payments which, in the case of a rental agreement, are for the use of the property during the period of temporary management, or which, in the case of a purchase agreement, become due during that same period;

ix. have full power to direct, manage, and discipline employees of the nursing facility, subject to any contract rights they have. The temporary manager shall not discharge employees without authorization from the Department of Health and Hospitals and notice to the owner. Temporary management shall not relieve the owner of any obligation to employees made prior to the appointment of a temporary manager and not carried out by the temporary manager;

x. preserve all property or assets of residents which are in the possession of a nursing facility or its owner; preserve all property or assets and all resident records of which the temporary manager takes possession; and provide for the prompt transfer of the property, assets, and records to the new placement of any transferred resident. An inventory list certified by the owner and temporary manager shall be made at the time the temporary manager takes possession of the nursing facility.

5. Procedure for Payments to Temporary Manager of Debts Owed to the Facility

a. As soon as possible after the effective date of appointment of the temporary manager but in no event later than ten days thereafter, the owner and administrator shall inform the temporary manager of the names and addresses of all persons owing money to the facility and of the amounts owed.

b. The temporary manager shall be the proper recipient of all funds due and owing to the facility from and after the effective date of appointment regardless of whether such funds are for goods or services rendered before or after the effective date of appointment, and the owner and administrator shall immediately transfer to the temporary manager any such funds received by either of them after the effective date of appointment.

c. The temporary manager shall notify persons making payments to the facility of the appointment of a temporary manager.

d. A person who is notified of the Department of Health and Hospital's appointment of a temporary manager and of the temporary manager's name and address shall be liable to pay the temporary manager for any goods or services provided by the temporary manager after the date of the appointment, if the person would have been liable for the goods and services as supplied by the owner.

e. The temporary manager shall give a receipt for each payment and shall keep a copy of each receipt on file.

f. The temporary manager shall deposit amounts received in a separate account and may make disbursements from such account. The temporary manager may bring an action to enforce liabilities created by the foregoing provisions.

g. A payment to the temporary manager of any sum owing to the nursing facility or to its owner shall discharge any obligation to the nursing facility to the extent of the payment.

6. Qualifications and Compensation of a Temporary Manager

a. The Department of Health and Hospitals shall appoint to serve as a temporary manager any person qualified by education and the requisite experience in nursing home administration and who is licensed in accordance with Louisiana law.

b. A temporary manager shall have no financial or fiduciary interest in the facility or any affiliated entities. No temporary manager shall be appointed who is affiliated with a management firm under an order of decertification in Louisiana or another state.

c. The Department of Health and Hospitals shall set the necessary expense of the temporary management. Said compensation shall be in line with the prevailing wage in the nursing home field and shall be charged as an expense to the facility for which the manager is appointed. The department may seek reimbursement for such expenses by deducting the appropriate amount from funds due or payable to the facility.

7. Personal Liability of the Temporary Manager

a. A temporary manager may be held liable in a personal capacity for the temporary manager's gross negligence, intentional acts, or breach of fiduciary duty, but otherwise, the acts and omissions of such temporary manager will be defended and discharged by the department.

b. The Department of Health and Hospitals shall secure a bond to cover any acts of negligence or mismanagement committed by the temporary manager when not covered by the facility's insurance.

8. Termination of Temporary Management. Temporary management shall be terminated when it is determined that:

a. the conditions which gave rise to the temporary management no longer exist; or

b. all of the Title XVIII (Medicare) and XIX (Medicaid) residents in the nursing facility have been transferred or discharged and the facility is no longer certified as a provider in the Medicare or Medicaid programs; or

c. the temporary manager has concluded all financial and patient care responsibilities, and

d. determination has been made that the party assuming responsibility for continued operation of the facility is capable of competently managing the facility in compliance with all requirements.

9. Notice of Appeal. Procedures described in the Notice and Appeal Procedure of this Subchapter §10167 shall apply.

I. Revocation of License

a. The Secretary of the Department of Health and Hospitals may deny an application for a license or refuse to renew a license or may revoke an outstanding license when an investigation reveals that the applicant or licensee is in non-conformance with or in violation of the provisions of R.S. 40:2009:6; provided that in all such cases, the Secretary shall furnish the applicant or licensee 30 calendar days written notice specifying reasons for the action.

b. The secretary, in a written notice of denial, non-renewal, or revocation of a license shall notify the applicant or licensee of his right to file a suspensive appeal with the Office of the Secretary within 30 calendar days from the date the notice, as described in this Subchapter §10167 in Notice and Appeal Procedure, is received by him. This appeal or request for a hearing shall specify in detail reasons why the appeal is lodged and why the appellant feels aggrieved by the action of the secretary.

c. When any appeal as described in the Notice and Appeal Procedure of this Subchapter is received by the secretary, if timely filed, he shall appoint an impartial three member board to conduct a hearing on the appeal at such time and place as such members deem proper, and after such hearing to render a written opinion on the issues presented at the hearing. The written decision or opinion of a majority of the members conducting the hearing shall constitute final administrative action on the appeal.

d. Any member of said board or the Secretary shall have power to administer oaths and to subpoena witnesses on behalf of the board or any party in interest and compel the production of books and papers pertinent to any investigation or hearing authorized by this subchapter, provided that in all cases witness fees and transportation and similar hearing costs shall be paid by the appellant or by the Department of Health and Hospitals if the appellant is found innocent of charges. Any person having been served with a subpoena who shall fail to appear in response to the subpoena or fail or refuse to answer any question or fail to produce any books or papers pertinent to any investigation or hearing or who shall knowingly give false testimony therein shall be guilty of a misdemeanor and shall upon conviction be punished by a fine of not less than one hundred dollars nor more than five hundred dollars or by imprisonment of not less than one month nor more than six months, or by both such fine and imprisonment.

J. Penalty for Falsification of Resident Assessment

1. An individual who willfully and knowingly certifies a material and false statement in a residents assessment is subject to a civil money penalty of not more than $1,000.00 with respect to each assessment.

2. An individual who willfully and knowingly causes another individual to certify a material and false statement in a resident assessment is subject to a civil penalty of not more than $5,000.00 with respect to each assessment.

3. The notice and appeal procedures described previously apply.

K. Residents' Trust Fund

1. The Residents' Trust Fund, hereinafter referred to as the "trust fund" is hereby established in the Department of Health and Hospitals to receive monies collected from civil fines levied against nursing homes found to have been in violation of regulations of the department. Monies deposited in the trust fund shall be used to support social welfare programs for the aid and support of the needy residents of nursing homes, and to achieve that purpose the department is hereby authorized to enter into cooperative endeavor agreements with public and private entities. The monies deposited shall be segregated from other funds of the State or the department and shall be designated exclusively for the uses and purposes of this section. All monies of the Trust Fund shall be deposited in an interest bearing account under the supervision of the State Treasurer. Interest on these monies shall be retained in the trust fund.

2. The monies in the trust fund may be used for the following purposes:

a. to protect the health or property of residents of nursing homes which the department finds deficient;

b. to pay for the cost of relocation of residents to other facilities;

c. to maintain operation of a facility pending correction of deficiencies or closure; and

d. to reimburse residents for personal funds lost.

3. Monies from the trust fund shall be utilized only to the extent that private or public funds, including funds available under Title XVIII (Medicare) and Title XIX (Medicaid) of the Social Security Act, are not available or are not sufficient to meet the expenses of the facility. The Secretary of the Department shall conserve the resources of the Trust Fund and shall only authorize expenditures that are consistent with usual and customary charges.

4. Disbursements may be approved for charges in excess of usual and customary charges if the secretary provides adequate written explanation of the need for such disbursement to the House and Senate Health and Welfare Committees within five days of authorizing such disbursement.

5. The existence of the trust fund shall not make the department responsible for the maintenance of residents of a nursing home facility or maintenance of the facility itself.

6. The trust fund shall be administered by the secretary of the department or his designee. Requests for monies from the trust fund may be made by a nursing home administrator or owner, a resident of the facility, or a resident's relative, conservator, guardian, or representative. The applicant must submit a completed fund request form to the secretary of the department. Forms may be obtained from the department, which shall maintain an adequate supply of such forms in all state and parish offices. A decision shall be provided within seven days of the request.

7. If an emergency exists, the applicant may request immediate consideration by notifying the secretary of the department by telephone, indicating the seriousness and immediate nature of the request. The secretary may orally authorize immediate disbursement but proper documentation or reasons for the disbursement and all completed forms must be filed in the office of the secretary within five days thereafter.

8. The department shall make an annual accounting to the Division of Administration of all monies received in the Trust Fund and all disbursements of those monies.

9. The terms of repayment, if any, of monies disbursed from the trust fund shall be determined by the secretary of the department and may, where appropriate, be set forth in a contract signed by the secretary and the applicant or other party responsible for repayment.

10. Failure to repay the funds according to the established schedule may, at the discretion of the Secretary, prevent future disbursements to the applicant from the trust fund until all monies are repaid. Monies due and owing to reimburse the trust fund shall accrue interest at a rate of two percent above the prime lending rate, unless a different rate is specified in the repayment agreement. The secretary may authorize funds owed by the department to a nursing home facility to be transferred into the trust fund in order to reimburse amounts owed by the facility to the Trust Fund.

AUTHORITY NOTE: Promulgated in accordance with R.S. 46:153.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 22:34 (January 1996).

Subpart 5. Reimbursement

Editor's Note: This Subpart has been moved from LAC 50:VII.Chapter 13 and renumbered.

Chapter 200. Reimbursement Methodology

§20001. General Provisions

A. Definitions

Active Assessment—a resident MDS assessment is considered active when it has been accepted by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS). The assessment will remain active until a subsequent minimum data set (MDS) assessment for the same resident has been accepted by CMS, the maximum number of days (121) for the assessment has been reached, or the resident has been discharged.

Administrative and Operating Cost Component—the portion of the Medicaid daily rate that is attributable to the general administration and operation of a nursing facility.

Assessment Reference Date—the date on the minimum data set (MDS) used to determine the due date and delinquency of assessments.

Base Resident-Weighted Median Costs and Prices—the resident-weighted median costs and prices calculated in accordance with §20005 of this rule during rebase years.

Calendar Quarter—a three-month period beginning January 1, April 1, July 1, or October 1.

Capital Cost Component—the portion of the Medicaid daily rate that is:

a. attributable to depreciation;

b. capital related interest;

c. rent; and/or

d. lease and amortization expenses.

Care Related Cost Component—the portion of the Medicaid daily rate that is attributable to those costs indirectly related to providing clinical resident care services to Medicaid recipients.

Case Mix—a measure of the intensity of care and services used by similar residents in a facility.

Case-Mix Documentation Review (*CMDR*)—a review of original legal medical record documentation and other documentation as designated by the department in the MDS supportive documentation requirements, supplied by a

nursing facility provider to support certain reported values that resulted in a specific RUG classification on a randomly selected MDS assessment sample. The review of the documentation provided by the nursing facility will result in the RUG classification being supported or unsupported.

Case-Mix Index (*CMI*)—a numerical value that describes the resident's relative resource use within the groups under the resource utilization group (RUG-III) classification system, or its successor, prescribed by the department based on the resident's MDS assessments. CMIs will be determined for each nursing facility on a quarterly basis using all residents.

Case-Mix MDS Documentation Review (*CMDR*)—a review of original legal medical record documentation on a randomly selected MDS assessment sample. The original legal medical record documentation supplied by the nursing facility is to support certain reported values that resulted in a specific RUG classification. The review of the documentation provided by the nursing facility will result in the RUG classification being supported or unsupported.

Cost Neutralization—refers to the process of removing cost variations associated with different levels of resident case mix. Neutralized cost is determined by dividing a facility's per diem direct care costs by the facility cost report period case-mix index.

Delinquent MDS Resident Assessment—an MDS assessment that is more than 121 days old, as measured by the assessment reference date (ARD) field on the MDS.

Department—the Louisiana Department of Health (LDH), or its successor, and the associated work product of its designated contractors and agents.

Direct Care Cost Component—the portion of the Medicaid daily rate that is attributable to:

a. registered nurse (RN), licensed practical nurse (LPN) and nurse aide salaries and wages;

b. a proportionate allocation of allowable employee benefits; and

c. the direct allowable cost of acquiring RN, LPN and nurse aide staff from outside staffing companies.

Final Case-Mix Index Report (FCIR)—the final report that reflects the acuity of the residents in the nursing facility.

a. Prior to the January 1, 2017 rate setting, resident acuity is measured utilizing the point-in-time acuity measurement system.

b. Effective with the January 1, 2017 rate setting, resident acuity will be measured utilizing the time-weighted acuity measurement system.

Index Factor—based on the *Skilled Nursing Home without Capital Market Basket Index* published by IHS Global Insight (IHS Economics), or a comparable index if this index ceases to be published.

MDS Supportive Documentation Requirements—the department's publication of the minimum documentation and review standard requirements for the MDS items associated with the RUG-III or its successor classification system. These requirements shall be maintained by the department and updated and published as necessary.

Minimum Data Set (MDS)—a core set of screening and assessment data, including common definitions and coding categories that form the foundation of the comprehensive assessment for all residents of long-term care nursing facility providers certified to participate in the Medicaid Program. The items in the MDS standardize communication about resident problems, strengths, and conditions within nursing facility providers, between nursing facility providers, and between nursing facility providers and outside agencies. The Louisiana system will employ the current required MDS assessment as approved by the Centers for Medicare and Medicaid Services (CMS), or as mandated by the Department of Health through the use of optional state assessment (OSA).

Nursing Facility Cost Report Period Case Mix Index—the average of quarterly nursing facility-wide average case mix indices, carried to four decimal places. The quarters used in this average will be the quarters that most closely coincide with the nursing facility provider's cost reporting period that is used to determine the medians. This average includes any revisions made due to an on-site CMDR.

a. For the cost reporting periods utilized in the next rebase of rates on or after July 1, 2017, the calendar quarter case mix index averages will be calculated using the time-weighted acuity measurement system, and be inclusive of MDS assessments available as of the date of the applicable quarterly FCIRs. This average includes any revisions made due to an on-site CMDR.

EXAMPLE: A January 1, 2015-December 31, 2015 cost report period would use the time-weighted facility-wide average case mix indices calculated for the four quarters ending March 31, 2015, June 30, 2015, September 30, 2015 and December 31, 2015.

Nursing Facility-Wide Average Case Mix Index—the simple average, carried to four decimal places, of all resident case mix indices.

a. Prior to the January 1, 2017, rate setting resident case mix indices will be calculated utilizing the point-in-time acuity measurement system. If a nursing facility provider does not have any residents as of the last day of a calendar quarter or the average resident case mix indices appear invalid due to temporary closure or other circumstances, as determined by the department, a statewide average case mix index using occupied and valid statewide nursing facility case mix indices may be used.

i. Effective as of the January 1, 2017 rate setting, resident case mix indices will be calculated utilizing the time-weighted acuity measurement. If a nursing facility provider does not have any residents during the course of a calendar quarter, or the average resident case mix indices appear invalid due to temporary closure or other circumstances, as determined by the department, a statewide

average case mix index using occupied and valid statewide nursing facility provider case mix indices may be used.

Pass-Through Cost Component—includes the cost of property taxes and property insurance. It also includes the provider fee as established by the Department of Health.

Point-In-Time Acuity Measurement System (*PIT*)—the case mix index calculation methodology that is compiled utilizing the active resident MDS assessments as of the last day of the calendar quarter, referred to as the point-in-time.

Preliminary Case-Mix Index Report (*PCIR*)—the preliminary report that reflects the acuity of the residents in the nursing facility.

a. Prior to the January 1, 2017 rate setting, resident acuity is measured utilizing the point-in-time acuity measurement system.

b. Effective as of the January 1, 2017 rate setting, resident acuity will be measured utilizing the time-weighted acuity measurement system.

RUG-III Resident Classification System—the resource utilization group used to classify residents. When a resident classifies into more than one RUG-III, or its successor's group, the RUG-III or its successor's group with the greatest CMI will be utilized to calculate the nursing facility provider's total residents average CMI and Medicaid residents average CMI.

Rate Year—a one-year period from July 1 through June 30 of the next calendar year during which a particular set of rates are in effect. It corresponds to a state fiscal year.

Resident-Day-Weighted Median Cost—a numerical value determined by arraying the per diem costs and total actual resident days of each nursing facility from low to high and identifying the point in the array at which the cumulative total of all resident days first equals or exceeds half the number of the total resident days for all nursing facilities. The per diem cost at this point is the resident-day-weighted median cost.

Summary Review Results Letter—a letter sent to the nursing facility that reports the final results of the case-mix documentation review and concludes the review.

a. The summary review results letter will be sent to the nursing facility provider within 10 business days after the final exit conference date.

Supervised Automatic Sprinkler System—a system that operates in accordance with the latest adopted edition of the National Fire Protection Association's *Life Safety Code*. It is referred to hereafter as a *fire sprinkler system*.

Time-Weighted Acuity Measurement System (*TW*)—the case mix index calculation methodology that is compiled from the collection of all resident MDS assessments transmitted and accepted by CMS that are considered active within a given calendar quarter. The resident MDS assessments will be weighted based on the number of calendar days that the assessment is considered an active assessment within a given calendar quarter.

Two-Hour Rated Wall—a wall that meets American Society for Testing and Materials International (ASTM) E119 standards for installation and uses two-hour rated sheetrock.

Unsupported MDS Resident Assessment—an assessment where one or more data items that are used to classify a resident pursuant to the RUG-III, 34-group, or its successor's resident classification system is not supported according to the MDS supportive documentation requirements and a different RUG-III, or its successor, classification would result; therefore, the MDS assessment would be considered "unsupported."

B. Effective for the rate period of July 1, 2015 through June 30, 2016, the department shall suspend the provisions of LAC 50:II.Chapter 200 governing the reimbursement methodology for nursing facilities and impose the following provisions governing reimbursements for nursing facility services.

1. During this time period, no inflation factor will be applied to the base resident day weighted medians and prices calculated as of July 1, 2014.

2. All costs and cost components that are required by rule to be trended forward will only be trended forward to the midpoint of the 2015 state fiscal year (December 31, 2014).

3. The base capital per square foot value, land value per square foot, and per licensed bed equipment value utilized in the calculation of the fair rental value (FRV) component will be set equal to the value of these items as of July 1, 2014.

4. Base capital values for the Bed Buy-Back program (§20012) purposes will be set equal to the value of these items as of July 1, 2014.

5. Nursing facility providers will not have their weighted age totals for the FRV component calculation purposes increased by one year as of July 1, 2015.

6. As of the July 1, 2016 rate setting, nursing facility provider weighted age totals for the FRV component calculation purposes will be increased by two years to account for the suspended year of aging occurring as of the July 1, 2015 rating period.

7. No other provisions of LAC 50:II.Chapter 200 shall be suspended for this time period.

C. Effective for the rate period of July 1, 2017 through June 30, 2018, the department shall suspend the provisions of LAC 50:II.Chapter 200 governing the reimbursement methodology for nursing facilities and impose the following provisions governing reimbursements for nursing facility services.

1. During this time period, no inflation factor will be applied to the base resident day weighted medians and prices calculated as of July 1, 2016.

2. All costs and cost components that are required by rule to be trended forward will only be trended forward to

the midpoint of the 2017 state fiscal year (December 31, 2016).

3. The base capital per square foot value, land value per square foot, and per licensed bed equipment value utilized in the calculation of the fair rental value (FRV) component will be set equal to the value of these items as of July 1, 2016.

4. Base capital values for the Bed Buy-Back Program (LAC 50:II.20012) purposes will be set equal to the value of these items as of July 1, 2016.

5. Nursing facility providers will not have their weighted age totals for the FRV component calculation purposes increased by one year as of July 1, 2017.

6. As of the July 1, 2018 rate setting, nursing facility provider weighted age totals for the FRV component calculation purposes will be increased by two years to account for the suspended year of aging occurring as of the July 1, 2017 rate period.

7. No other provisions of LAC 50:II.Chapter 200 shall be suspended for this time period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1473 (June 2002), repromulgated LR 28:1790 (August 2002), amended LR 28:2537 (December 2002), LR 32:2262 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:825 (March 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 42:1522 (September 2016), LR 43:525 (March 2017), LR 43:2187 (November 2017), LR 46:695 (May 2020).

§20003. Cost Reports [Formerly LAC 50:VII.1303]

A. Nursing facility providers under Title XIX are required to file annual cost reports as follows.

1. Providers of nursing facility level of care are required to report all reasonable and allowable cost on a regular nursing facility cost report. Effective for periods ending on or after June 30, 2002, the regular nursing facility cost report will be the skilled nursing facility cost report adopted by the Medicare program, hereafter referred to as the Medicare cost report. This cost report is frequently referred to as the Health Care Financing Administration (HCFA) 2540. The cost reporting period begin date shall be the later of the first day of the facility's fiscal period or the facility's certification date. The cost reporting end date shall be the earlier of the last day of the facility's fiscal period or the final day of operation as a nursing facility.

2. In addition to filing the Medicare cost report, nursing facility providers must also file supplemental schedules designated by the bureau. Facilities shall submit their Medicare cost report and their state Medicaid supplemental cost report in accordance with procedures established by the department.

3. Separate cost reports must be submitted by central/home offices when costs of the central/home office are reported in the facility's cost report.

B. Cost reports must be prepared in accordance with the cost reporting instructions adopted by the Medicare Program using the definition of allowable and non-allowable cost contained in the CMS Publication 15-1, Provider Reimbursement Manuals, with the following exceptions.

1. Cost reports must be submitted annually. The due date for filing annual cost reports is the last day of the fifth month following the facility's fiscal year end.

2. There shall be no automatic extension of the due date for the filing of cost reports. If a provider experiences unavoidable difficulties in preparing its cost report by the prescribed due date, one 30-day extension may be permitted, upon written request submitted to the department prior to the due date. The request must explain in detail why the extension is necessary. Extensions beyond 30 days may be approved for situations beyond the facility's control. An extension will not be granted when the provider agreement is terminated or a change in ownership occurs.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1473 (June 2002), repromulgated LR 28:1790 (August 2002), amended LR 28:2537 (December 2002), LR 32:2263 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:541 (March 2014), amended by the Department of Health, Bureau of Health Services Financing, LR 43:526 (March 2017).

§20005. Rate Determination [Formerly LAC 50:VII.1305]

A. For dates of service on or after July 1, 2002, each nursing facility's rate for skilled nursing (SN), intermediate care I (IC-I) and intermediate care II (IC-II) services shall be the daily rates for these services in effect on June 30, 2002 as adjusted by legislative appropriations for state fiscal year 2003.

B. For dates of service on or after January 1, 2003, the Medicaid daily rates shall be based on a case-mix price-based reimbursement system. Rates shall be calculated from cost report and other statistical data.

1. Effective July 3, 2009, and at a minimum, every second year thereafter, the base resident-day-weighted median costs and prices shall be rebased using the most recent four month or greater unqualified audited or desk reviewed cost reports that are available as of the April 1, prior to the July 1, rate setting or the department may apply a historic audit adjustment factor to the most recently filed cost reports. The department, at its discretion, may rebase at an earlier time.

a. For rate periods between rebasing, an index factor shall be applied to the base resident-day weighted medians and prices.

C. Each facility's Medicaid daily rate is calculated as:

1. the sum of the facility's direct care and care related price;

2. the statewide administrative and operating price;

3. each facility's capital rate component;

4. each facility's pass-through rate component;

5. adjustments to the rate; and

6. the statewide durable medical equipment price.

D. Determination of Rate Components

1. Facility Specific Direct Care and Care Related Component. This portion of a facility's rate shall be determined as follows.

a. The per diem direct care cost for each nursing facility is determined by dividing the facility's direct care cost during the base year cost reporting period by the facility's actual total resident days during the cost reporting period. These costs shall be trended forward from the midpoint of the facility's base year cost report period to the midpoint of the rate year using the index factor. The per diem neutralized direct care cost is calculated by dividing each facility's direct care per diem cost by the facility cost report period case-mix index.

b. The per diem care related cost for each nursing facility is determined by dividing the facility's care related cost during the base year cost reporting period by the facility's actual total resident days during the base year cost reporting period. These costs shall be trended forward from the midpoint of the facility's base year cost report period to the midpoint of the rate year using the index factor.

c. The per diem neutralized direct care cost and the per diem care related cost is summed for each nursing facility. Each facility's per diem result is arrayed from low to high and the resident-day-weighted median cost is determined. Also for each facility, the percentage that each of these components represents of the total is determined.

d. Effective July 1, 2011, the statewide direct care and care related price is established at 112.40 percent of the direct care and care related resident-day-weighted median cost.

e. The statewide direct care and care related floor is established at 94 percent of the direct care and care related resident-day-weighted median cost. For periods prior to January 1, 2007 the statewide direct care and care related floor shall be reduced to 90 percent of the direct care and care related resident-day-weighted median cost in the event that the nursing wage and staffing enhancement add-on is removed. Effective January 1, 2007 the statewide direct care and care related floor shall be reduced by one percentage point for each 30 cent reduction in the average Medicaid rate due to a budget reduction implemented by the department. The floor cannot be reduced below 90 percent of the direct care and care related resident-day-weighted median cost.

f. For each nursing facility, the statewide direct care and care related price shall be apportioned between the per diem direct care component and the per diem care related component using the facility-specific percentages determined in §1305.D.1.c. On a quarterly basis, each facility's specific direct care component of the statewide price shall be multiplied by each nursing facility's average case-mix index for the prior quarter. The direct care component of the statewide price will be adjusted quarterly to account for changes in the facility-wide average case-mix index. Each facility's specific direct care and care related price is the sum of each facility's case mix adjusted direct care component of the statewide price plus each facility's specific care related component of the statewide price.

g. For each nursing facility, the statewide direct care and care related floor shall be apportioned between the per diem direct care component and the per diem care related component using the facility-specific percentages determined in §1305.D.1.c. On a quarterly basis, each facility's specific direct care component of the statewide floor shall be multiplied by each facility's average case-mix index for the prior quarter. The direct care component of the statewide floor will be adjusted quarterly to account for changes in the facility-wide average case-mix index. Each facility's specific direct care and care related floor is the sum of each facility's case mix adjusted direct care component of the statewide floor plus each facility's specific care related component of the statewide floor.

i. Effective for rate periods January 1, 2017 through June 30, 2017 each nursing facility providers direct care and care related floor will be calculated as follows.

(a). For each nursing facility, the statewide direct care and care related floor shall be apportioned between the per diem direct care component and the per diem care related component using the facility-specific percentages determined in Subparagraph c of this Paragraph. On a quarterly basis, each facility's specific direct care component of the statewide floor shall be multiplied by each nursing facility provider's most advantageous average case mix index for the prior quarter. The most advantageous case mix index will be determined by utilizing the nursing facility providers' calculated point-in-time or time-weighted measurement system case mix index value that results in the lowest direct care and care related floor amount for the associated rate quarter. The direct care component of the statewide floor will be adjusted quarterly to account for changes in the nursing facility-wide average case mix index. Each facility's specific direct care and care related floor is the sum of each facility's case mix adjusted direct care component of the statewide floor plus each facility's specific care related component of the statewide floor.

h. Effective with cost reporting periods beginning on or after January 1, 2003, a comparison will be made between each facility's direct care and care related per diem cost and the direct care and care related cost report period per diem floor. If the total direct care and care related per diem cost the facility incurred is less than the cost report period per diem floor, the facility shall remit to the bureau the difference between these two amounts times the number of Medicaid days paid during the cost reporting period. The

cost report period per diem floor shall be calculated using the calendar day-weighted average of the quarterly per diem floor calculations for the facility's cost reporting period.

EXAMPLE: A May 1, 2003-April 30, 2004 cost report period would use the average of the per diem floor calculations for April 1, 2003 (weighted using 61 days), July 1, 2003 (weighted using 92 days), October 1, 2003 (weighted using 92 days), January 1, 2004 (weighted using 91 days) and April 1, 2004 (weighted using 30 days).

i. For dates of service on or after July 3, 2009, the facility-specific direct care rate will be adjusted in order to reduce the wage enhancement from $4.70 to a $1.30 wage enhancement prior to the case-mix adjustment for direct care staff. The $1.30 wage enhancement will be included in the direct care component of the floor calculations. It is the intent that this wage enhancement be paid to the direct care staff.

i. Effective with the next rebase, on or after July 1, 2010, the wage enhancement will be eliminated.

2. The administrative and operating component of the rate shall be determined as follows.

a. The per diem administrative and operating cost for each nursing facility is determined by dividing the facility's administrative and operating cost during the base year cost reporting period by the facility's actual total resident days during the base year cost reporting period. These costs shall be trended forward from the midpoint of the facility's base year cost report period to the midpoint of the rate year using the index factor.

b. Each facility's per diem administrative and operating cost is arrayed from low to high and the resident-day-weighted median cost is determined.

c. The statewide administrative and operating price is established at 107.5 percent of the administrative and operating resident-day-weighted median cost.

3. The capital component of the rate for each facility shall be determined as follows.

a. The capital cost component rate shall be based on a fair rental value (FRV) reimbursement system. Under a FRV system, a facility is reimbursed on the basis of the estimated current value, also referred to as the current construction costs, of its capital assets in lieu of direct reimbursement for depreciation, amortization, interest and rent/lease expenses. The FRV system shall establish a nursing facility's bed value based on the age of the facility and its total square footage.

b. Effective January 1, 2003, the new value per square foot shall be $97.47. This value per square foot shall be increased by $9.75 for land plus an additional $4,000 per licensed bed for equipment. This amount shall be trended forward annually to the midpoint of the rate year using the change in the unit cost listed in the three-fourths column of the R.S. means building construction data publication or a comparable publication if this publication ceases to be published, adjusted by the weighted average total city cost index for New Orleans, LA. The cost index for the midpoint of the rate year shall be estimated using a two-year moving average of the two most recent indices as provided in this Subparagraph. A nursing facility's fair rental value per diem is calculated as follows.

i. Each nursing facility's actual square footage per bed is multiplied by the January 1, 2003 new value per square foot, plus $9.75 for land. The square footage used shall not be less than 300 square feet or more than 450 square feet per licensed bed. To this value add the product of total licensed beds times $4,000 for equipment, sum this amount and trend it forward using the capital index. This trended value shall be depreciated, except for the portion related to land, at 1.25 percent per year according to the weighted age of the facility. Bed additions, replacements and renovations shall lower the weighted age of the facility. The maximum age of a nursing facility shall be 30 years. Therefore, nursing facilities shall not be depreciated to an amount less than 62.5 percent or [100 percent minus (1.25 percent*30)] of the new bed value. There shall be no recapture of depreciation.

ii. A nursing facility's annual fair rental value (FRV) is calculated by multiplying the facility's current value times a rental factor. The rental factor shall be the 20-year treasury bond rate as published in the *Federal Reserve Bulletin* using the average for the calendar year preceding the rate year plus a risk factor of 2.5 percent with an imposed floor of 9.25 percent and a ceiling of 10.75 percent.

iii. Effective July 1, 2011, the nursing facility's annual fair rental value shall be divided by the greater of the facility's annualized actual resident days during the cost reporting period or 85 percent of the annualized licensed capacity of the facility to determine the FRV per diem or capital component of the rate. Annualized total patient days will be adjusted to reflect any increase or decrease in the number of licensed beds as of the date of rebase by applying to the increase or decrease the greater of the facility's actual occupancy rate during the base year cost report period or 85 percent of the annualized licensed capacity of the facility.

iv. The initial age of each nursing facility used in the FRV calculation shall be determined as of January 1, 2003, using each facility's year of construction. This age will be reduced for replacements, renovations and/or additions that have occurred since the facility was built provided there is sufficient documentation to support the historical changes. The age of each facility will be further adjusted each July 1 to make the facility one year older, up to the maximum age of 30 years. Beginning January 1, 2007 and the first day of every calendar quarter thereafter, the age of each facility will be reduced for those facilities that have completed and placed into service major renovation or bed additions. This age of a facility will be reduced to reflect the completion of major renovations and/or additions of new beds. If a facility adds new beds, these new beds will be averaged in with the age of the original beds and the weighted average age for all beds will be used as the facility's age. Changes in licensed beds are only recognized, for rate purposes, at July 1 of a rebase year unless the change in licensed beds is related to a change in square footage. The occupancy rate applied to a

facility's licensed beds will be based on the base year occupancy.

v. If a facility performed a major renovation/ improvement project (defined as a project with capitalized cost equal to or greater than $500 per bed), the cost of the renovation project will be used to determine the equivalent number of new beds that the project represents. The equivalent number of new beds from a renovation/improvement project will be determined by dividing the cost of the renovation/improvement project by the accumulated depreciation per bed of the facility's existing beds immediately before the renovation/improvement project. The equivalent number of new beds will be used to determine the weighted average age of all beds for this facility.

(a). Major renovation/improvement costs must be documented through cost reports, depreciation schedules, construction receipts or other auditable records. Costs must be capitalized in compliance with the Medicare provider reimbursement manual in order to be considered in a major renovation/improvement project. The cost of the project shall only include the cost of items placed into service during a time period not to exceed the previous 24 months prior to a re-aging. Entities that also provide non-nursing facility services or conduct other non-nursing facility business activities must allocate their renovation cost between the nursing facility and non-nursing facility business activities. Documentation must be provided to the department or its designee to substantiate the accuracy of the allocation of cost. If sufficient documentation is not provided, the renovation/improvement project will not be used to re-age the nursing facility.

(b). Weighted average age changes as a result of replacements/improvements and/or new bed additions must be requested by written notification to the department prior to the rate effective date of the change and separate from the annual cost report. The written notification must include sufficient documentation as determined by the department. All valid requests will become part of the quarterly case-mix FRV rate calculation beginning January 1, 2007.

4. Pass-Through Component of the Rate. The pass-through component of the rate is calculated as follows.

a. The nursing facility's per diem property tax and property insurance cost is determined by dividing the facility's property tax and property insurance cost during the base year cost reporting period by the facility's actual total resident days. These costs shall be trended forward from the midpoint of the facility's base year cost report period to the midpoint of the rate year using the index factor. The pass-through rate is the sum of the facility's per diem property tax and property insurance cost trended forward plus the provider fee determined by the Department of Health and Hospitals.

b. Effective August 1, 2005, the pass-through rate will include a flat statewide fee for the cost of durable medical equipment and supplies required to comply with the plan or care for Medicaid recipients residing in nursing facilities. The flat statewide fee shall remain in place until the cost of the durable medical equipment is included in rebase cost reports, as determined under §1305.B, at which time the department may develop a methodology to incorporate the durable medical equipment cost in to the case-mix rate.

c. Effective September 1, 2016, the pass through rate shall be increased as a result of the provider fee increase on nursing facility days from $10.00 per day up to $12.08 per day per occupied bed.

d. Effective for rate periods beginning January 1, 2017 through June 30, 2017, each applicable nursing facility provider will receive an additional pass-through rate adjustment to allow for a phase-in of the time-weighted acuity measurement system. The nursing facility provider pass-through rate adjustment will be calculated and applied as follows.

i. The nursing facility provider’s rate period reimbursement rate will be calculated in accordance with §20005.B using the point-in-time acuity measurement system for determining the nursing facility-wide average case mix index values. The reimbursement rate will be determined after considering all other rate period changes to the reimbursement rates.

ii. The nursing facility provider’s rate period reimbursement rate will be calculated in accordance with §20005.B using the time-weighted acuity measurement system for determining the nursing facility-wide average case mix index values. The reimbursement rate will be determined after considering all other rate period changes to the reimbursement rate.

iii. The reimbursement rate differential will be determined by subtracting the reimbursement rate calculated using the point-in-time acuity measurement system from the reimbursement rate calculated using the time-weighted acuity measurement system.

iv. If the calculated reimbursement rate differential exceeds a positive or negative $2, then a pass-through rate adjustment will be applied to the nursing facility provider’s reimbursement rate in an amount equal to the difference between the rate differential total and the $2 threshold, in order to ensure the nursing facility provider’s reimbursement rate is not increased or decreased more than $2 as a result of the change of the time-weighted acuity measurement system.

(a). Should the nursing facility provider, for the aforementioned rate periods, receive an adjusted nursing facility-wide average case mix index value due to a CMDR change or other factors, the facility will have their rate differential recalculated using the revised case mix index values. The $2 reimbursement rate change threshold will apply to the recalculated differential and associated case mix index values, not the original differential calculation.

v. If a nursing facility provider’s calculated rate differential does not exceed the $2 rate change threshold,

then no pass-through rate adjustment will be applied for the applicable rate period.

5. Adjustment to the Rate. Adjustments to the Medicaid daily rate may be made when changes occur that will eventually be recognized in updated cost report data (such as a change in the minimum wage, a change in FICA or a utility rate change). These adjustments would be effective until the next rebasing of cost report data or until such time as the cost reports fully reflect the change.

6. Budget Shortfall. In the event the department is required to implement reductions in the nursing facility program as a result of a budget shortfall, a budget reduction category shall be created. Without changing the parameters established in these provisions, this category shall reduce the statewide average Medicaid rate by reducing the reimbursement rate paid to each nursing facility using an equal amount per patient day.

E. All capitalized costs related to the installation or extension of supervised automatic fire sprinkler systems or two-hour walls placed in service on or after July 1, 2006 will be excluded from the renovation/improvement costs used to calculate the FRV to the extent the nursing home is reimbursed for said costs in accordance with §1317.

F. Effective for dates of service on or after January 22, 2010, the reimbursement paid to non-state nursing facilities shall be reduced by 1.5 percent of the per diem rate on file as of January 21, 2010 ($1.95 per day).

G. Effective for dates of service on or after July 1, 2010, the per diem rate paid to non-state nursing facilities shall be reduced by an amount equal to 4.8 percent of the non-state owned nursing facilities statewide average daily rate on file as of July 1, 2010 until such time as the rate is rebased.

H. Effective for dates of service on or after July 1, 2011, the per diem rate paid to non-state nursing facilities, excluding the provider fee, shall be reduced by $26.98 of the rate in effect on June 30, 2011 until such time that the rate is rebased.

I. Effective for dates of service on or after July 1, 2012, the per diem rate paid to non-state nursing facilities, excluding the provider fee, shall be reduced by $32.37 of the rate in effect on June 30, 2012 until such time that the rate is rebased.

J. Effective for dates of service on or after July 1, 2012, the average daily rates for non-state nursing facilities shall be reduced by $4.11 per day of the average daily rate on file as of June 30, 2012 after the sunset of the state fiscal year 2012 rebase and before the state fiscal year 2013 rebase.

K. Effective for dates of service on or after July 1, 2012, the average daily rates for non-state nursing facilities shall be reduced by $1.15 per day of the average daily rate on file as of June 30, 2012 after the sunset of the state fiscal year 2012 rebase and after the state fiscal year 2013 rebase.

L. Effective for dates of service on or after July 20, 2012, the average daily rates for non-state nursing facilities shall be reduced by 1.15 percent per day of the average daily rate on file as of July 19, 2012 after the sunset of the state fiscal year 2012 rebase and after the state fiscal year 2013 rebase.

M. Effective for dates of service on or after September 1, 2012, the average daily rates for non-state nursing facilities shall be reduced by $13.69 per day of the average daily rate on file as of August 31, 2012 before the state fiscal year 2013 rebase which will occur on September 1, 2012.

N. Effective for dates of service on or after September 1,2012, the average daily rates for non-state nursing facilities shall be reduced by $1.91 per day of the average daily rate on file as of August 31, 2012 after the state fiscal year 2013 rebase which will occur on September 1, 2012.

O. Effective for dates of service on or after July 1, 2013, the per diem rate paid to non-state nursing facilities, excluding the provider fee, shall be reduced by $53.05 of the rate in effect on June 30, 2013 until such time that the rate is rebased.

P. Effective for dates of service on or after July 1, 2013, the per diem rate paid to non-state nursing facilities, excluding the provider fee, shall be reduced by $18.90 of the rate in effect on June 30, 2013 until such time that the rate is rebased.

Q. Effective for dates of service on or after July 1, 2014, the per diem rate paid to non-state nursing facilities shall be reduced by $90.26 of the rate in effect on June 30, 2014 until such time that the rate is rebased.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1791 (August 2002), amended LR 31:1596 (July 2005), LR 32:2263 (December 2006), LR 33:2203 (October 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:325 (February 2010), repromulgated LR 36:520 (March 2010), amended LR 36:1556 (July 2010), LR 36:1782 (August 2010), LR 36:2566 (November 2010), LR 37:902 (March 2011), LR 37:1174 (April 2011), LR 37:2631 (September 2011), LR 38:1241 (May 2012), LR 39:1286 (May 2013), LR 39:3097, 3097 (November 2013), LR 41:707 (April 2015), LR 41:949 (May 2015), amended by the Department of Health, Bureau of Health Services Financing, LR 43:82 (January 2017), LR 43:526 (March 2017).

§20006. Reimbursement Adjustment [Formerly LAC 50:VII.1306]

A. Effective for dates of service on or after January 1, 2004, for state fiscal year 2003-2004 only, each private nursing facility's per diem case mix adjusted rate shall be reduced by $0.67.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 30:804 (April 2004).

§20007. Case-Mix Index Calculation [Formerly LAC 50:VII.1307]

A. The Resource Utilization Groups-III (RUG-III) Version 5.20, 34-group, or its successor, index maximizer model shall be used as the resident classification system to determine all case-mix indices, using data from the minimum data set (MDS) submitted by each facility. Standard Version 5.20, or its successor, case-mix indices developed by CMS shall be the basis for calculating average case-mix indices to be used to adjust the direct care cost component. Resident assessments that cannot be classified to a RUG-III group, or its successor, will be excluded from the average case-mix index calculation.

B. Each resident in the nursing facility, with a completed and submitted assessment, shall be assigned a RUG-III, 34-group, or its successor based on the following criteria.

1. Prior to the January 1, 2017 rate setting, the RUG-III group, or its successor, is calculated based on the resident's most current assessment, available on the last day of each calendar quarter, and shall be translated to the appropriate case mix index. From the individual resident case mix indices, two average case mix indices for each Medicaid nursing facility provider shall be determined four times per year based on the last day of each calendar quarter.

2. Effective as of the January 1, 2017 rate setting, the RUG-III group, or its successor, will be calculated using each resident MDS assessment transmitted and accepted by CMS that is considered active within a given calendar quarter. These assessments are then translated to the appropriate case mix index. The individual resident case mix indices are then weighted based on the number of calendar days each assessment is active within a given calendar quarter. Using the individual resident case mix indices, the calendar day weighted average nursing facility-wide case mix index is calculated using all residents regardless of payer type. The calendar day weighted nursing facility-wide average case mix index for each Medicaid nursing facility shall be determined four times per year.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1475 (June 2002), repromulgated LR 28:1792 (August 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:826 (March 2012), LR 43:527 (March 2017).

§20009. Non-State, Government Owned or Operated Facilities and State-Owned or Operated Facilities

A. Non-state, government-owned or operated nursing facilities will be paid a case-mix reimbursement rate in accordance with §1305.

B. State-owned or operated nursing facilities will be paid a prospective per diem rate. The per diem payment rate for each of these facilities will be calculated annually on July 1, using the nursing facility's allowable cost from the most recently filed Medicaid cost report trended forward from the midpoint of the cost report year to the midpoint of the rate year using the index factor.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1793 (August 2002), amended LR 30:53 (January 2004), LR 31:1596 (July 2005), LR 32:2265 (December 2006), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 36:325 (February 2010), LR 36:520 (March 2010).

§20010. Additional Payments and Square Footage Adjustments for Private Room Conversion [Formerly LAC 50:VII.1310]

A. Effective for dates of service on or after September 1, 2007, Medicaid participating nursing facilities that convert a semi-private room to a Medicaid-occupied private room are eligible to receive an additional $5 per diem payment. Facilities that participate will have their fair rental value per diem revised based on the change in licensed beds.

B. Qualifying Facilities

1. In order for a nursing facility's beds to qualify for an additional $5 per diem payment, a revised fair rental value (FRV), a revised property tax pass-through, and revised property insurance pass-through, all of the following conditions must be met.

a. The nursing facility must convert one or more semi-private rooms to private rooms on or after September 1, 2007.

b. The converted private room(s) must be occupied by a Medicaid resident(s) to receive the $5 per diem payment.

c. The nursing facility must surrender their bed licenses equal to the number of converted private rooms.

d. The nursing facility must submit the following information to the department within 30 days of the private room conversion:

i. the number of rooms converted from semi-private to private;

ii. the revised bed license;

iii. a resident listing by payer type for the converted private rooms; and

iv. the date of the conversions.

C. The additional $5 per diem payment determination will be as follows.

1. An additional $5 will be added to the nursing facility's case-mix rate for each Medicaid resident day in a converted private room.

2. The payment will begin the first day of the following calendar quarter, after the facility meets all of the qualifying criteria in §1310.B.1.

3. A change in ownership, major renovation, or replacement facility will not impact the $5 additional per diem payment provided that all other provisions of this Section have been met.

D. The revised fair rental value per diem will be calculated as follows.

1. After a qualifying conversion of semi-private rooms to private rooms, the nursing facility's square footage will be divided by the remaining licensed nursing facility beds to calculate a revised square footage per bed.

2. After a qualifying private room conversion, the allowable square footage per bed used in §1305.D.3.b. will be determined as follows.

a. No Change in Total Square Footage. The total allowable square footage after a qualifying private room conversion will be equal to the total allowable square footage immediately prior to the conversion, provided no other facility renovations or alterations changing total square footage occur concurrently or subsequently to the private room conversion.

b. Square Footage Changes to Existing Buildings. If a change in total nursing square footage occurs in a building existing on the effective date of this rule and that change is concurrent or subsequent to a private room conversion, the allowable square footage will be determined in accordance with §1305.D.3.b.i as if the private room conversion did not occur.

c. Square Footage Changes Due to New Buildings. Replacement buildings constructed or first occupied after the effective date of this rule will have their allowable square footage calculated in accordance with §1305.D.3.b.i.

3. Resident days used in the fair rental value per diem calculation will be the greater of the annualized actual resident days from the base year cost report or 85 percent of the revised annual bed days available after the change in licensed beds.

4. A revised fair rental value per diem will be calculated under §1305.D.3.b. using the allowable square footage according to §1310.D.2, remaining licensed beds, and the revised minimum occupancy calculation.

5. The revised fair rental value per diem will be effective the first of the following calendar quarter, after the facility meets all qualifying criteria in paragraph §1310.B.1.

E. Reporting

1. To remain eligible for the conversion payments and the allowable square footage calculations, facilities must report Medicaid-occupied private rooms with every annual cost report.

2. The department may also require an alternate billing procedure for providers to receive the additional $5 private room rate.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 33:1646 (August 2007), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:794 (April 2014).

§20011. New Facilities, Changes of Ownership of Existing Facilities and Existing Facilities with Disclaimer or Non-Filer Status [Formerly LAC 50:VII.1311]

A. New facilities are those entities whose beds have not previously been certified to participate, or otherwise participated, in the Medicaid program. New facilities will be reimbursed in accordance with this rule using the statewide average case mix index to adjust the statewide direct care component of the statewide price and the statewide direct care component of the floor. The statewide direct care and care related price shall be apportioned between the per diem direct care component and the per diem care related component using the statewide average of the facility-specific percentages determined in §1305.D.1c. After the second full calendar quarter of operation, the statewide direct care and care related price and the statewide direct care and care related floor shall be adjusted by the facility's case mix index calculated in accordance with §1305.D.1.f-g and §1307 of this rule. The capital rate paid to a new facility will be based upon the age and square footage of the new facility. An interim capital rate shall be paid to a new facility at the statewide average capital rate for all facilities until the start of a calendar quarter two months or more after the facility has submitted sufficient age and square footage documentation to the department. Following receipt of the age and square footage documentation, the new facility's capital rate will be calculated using the facility's actual age and square footage and the statewide occupancy from the most recent base year and will be effective at the start of the first calendar quarter two months or more after receipt. New facilities will receive the statewide average property tax and property insurance rate until the facility has a cost report included in a base year rate setting. New facilities will also receive a provider fee that has been determined by the department.

B. A change of ownership exists if the beds of the new owner have previously been certified to participate, or otherwise participated, in the Medicaid program under the previous owner's provider agreement. Rates paid to facilities that have undergone a change in ownership will be based upon the acuity, costs, capital data and pass-through of the prior owner. Thereafter, the new owner's data will be used to determine the facility's rate following the procedures specified in this rule.

C. Existing facilities with disclaimer status includes any facility that receives a qualified audit opinion or disclaimer on the cost report used for rebase under §1305.B. Facilities with a disclaimed cost report status may have adjustments made to their rates based on an evaluation by the secretary of the department.

D. Existing facilities with non-filer status includes any facility that fails to file a complete cost report in accordance

with §1303. These facilities will have their case-mix rates adjusted as follows.

1. The statewide direct care and care related price shall be apportioned between the per diem direct care component and the per diem care related component using percentages that result in the lowest overall rate.

2. No property tax and insurance pass-through reimbursement shall be included in the case-mix rate.

3. The fair rental value rate calculated shall be based on 100 percent occupancy.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:1793 (August 2002), amended LR 32:2265 (December 2006).

§20012. Fair Rental Value, Property Tax and Property Insurance Incentive Payments to Buyers of Nursing Facilities [Formerly LAC 50:VII.1312]

A. On or after July 20, 2007, a Louisiana Medicaid participating nursing facility [buyer(s)] that purchases and closes an existing Louisiana Medicaid participating nursing facility (seller) will be eligible to receive fair rental value, property tax and property insurance incentive payments for five years after the legal transfer of ownership and closure of the seller's nursing facility.

B. Qualifying Buyer(s). In order for the buying facility to qualify for the incentive payments described in this Section, the following conditions must be met.

1. Buyer(s) must purchase and close a Medicaid-certified nursing facility within 90 days after the legal transfer of ownership from the seller to buyer(s).

2. After closing the facility, all buyer(s) must permanently surrender their interest in the seller's bed license and the Facility Need Review bed approvals to the state.

3. The buyer(s) must be a Medicaid-certified nursing facility operator(s) at the time of purchase and continue their Medicaid participation throughout the entire five year payment period. A change in ownership of a buyer facility will not be considered a break in Medicaid participation provided the new owner of the nursing facility continues participation in the Medicaid Program as a Medicaid-certified nursing facility.

4. The buyer(s) must provide the following documentation to the secretary of the department, in writing, within 30 days after the legal transfer of ownership:

a. a list of all buyer(s);

b. a list of all seller(s);

c. the date of the legal transfer of ownership;

d. each buyer's percentage share of the purchased facility; and

e. each buyer's current nursing facility resident listing and total occupancy calculations as of the date of the legal transfer of ownership.

5. The buyer(s) must provide the following documentation to the secretary of the department, in writing, within 110 days after the legal transfer of ownership:

a. a list of the nursing facility residents that transferred from the seller facility and were residents of the buyer facility as of 90 days after the legal transfer of ownership date. The nursing facility resident list must include the payer source for each resident;

b. the date that the seller's facility was officially closed and no longer operating as a nursing facility.

C. Incentive Calculation. The total annual Medicaid incentive payment for each transaction will be based on the number of beds surrendered from the closed facility and the cumulative percentage increase in occupancy for all buyers involved in the purchase.

1. Beds surrendered will be based on the licensed beds surrendered for the closed facility. The number of beds surrendered will determine the base capital amount used in the incentive payment calculation as follows.

a. Under 115 beds surrendered will result in a base capital amount of $303,216.

b. 115 through 144 beds surrendered will result in a base capital amount of $424,473.

c. 145 beds or more surrendered will result in a base capital amount of $597,591.

2. The cumulative increase in total nursing facility occupancy for all buyers involved in the transaction will be calculated based on the total occupancy reported for all buyers at the purchase date as required by §1312.B.4.e and the reported increase in total residents received from the seller as required by §1312.B.5.a.

a. Cumulative occupancy increases for all buyers will determine the percentage of the base capital amount used in the incentive payment calculation as follows:

i. less than 5.00 percent will result in 67 percent of the base capital amount;

ii. 5.00 percent through 9.99 percent will result in 78 percent of the base capital amount;

iii. 10.00 percent through 14.99 percent will result in 89 percent of the base capital amount;

iv. 15.00 percent and up will result in 100 percent of the base capital amount.

3. Annual Medicaid Incentive Payment Calculation. The payment amount that corresponds to the cumulative occupancy increase for all buyers and the number of beds surrendered will be multiplied by each buyer's percentage share in the transaction as reported in accordance with §1312.B.4.d. The result will be each buyer's total annual Medicaid incentive payment for five years.

4. Base Capital Amount Updates. On July 1 of each year, the base capital amounts (as defined in Paragraph 1 of this Subsection) will be trended forward annually to the midpoint of the rate year using the change in the per diem unit cost listed in the three-fourths column of the R.S. Means Building Construction Data Publication, or its successor, adjusted by the weighted average total city cost index for New Orleans, LA. The cost index for the midpoint of the rate year shall be estimated using a two-year moving average of the two most recent indices as provided in this Paragraph. Adjustments to the base capital amount will only be applied to purchase and closure transactions occurring after the adjustment date.

D. Re-Base of Buyers' Fair Rental Value, Property Tax, and Property Insurance per Diems. All buyers will have their fair rental value, property tax, and property insurance per diems re-based using the number of residents reported by each buyer as required by §1312.B.5.a. The re-base will be retroactive to the date of closure of the purchased facility. The calculation will be as follows.

1. Prior to application of the minimum occupancy calculation, the actual number of total resident days used in the calculation of each buyer's current fair rental value per diem as described in §1305.D.3.b.iii will be increased by the number of residents the buyer reported under §1312.B.5.a multiplied by the total number of current rate year days.

2. The number of total resident days used in the calculation of each buyer's current pass through property tax and insurance per diem as described under §1305.D.4.a will be increased by the number of residents the buyer reported under §1312.B.5.a multiplied by the number of calendar days included in the buyer's most recent base-year cost report.

3. The resident day adjustment to each buyer's fair rental value, property tax, and property insurance per diem will continue until the buyer's base-year cost report, as defined under §1305.B, includes a full 12 months of resident day data following the closure of the acquired facility (seller). If a buyer's base year cost report overlaps the closure date of the acquired facility, a proportional adjustment to that buyer's resident days will be made for use in the fair rental value, property tax, and property insurance per diem calculations.

E. Payments

1. The fair rental value, property tax and property insurance incentive payment will be paid to the buyer(s) as part of their Medicaid per diem for current services billed over five years (20 quarters), effective the beginning of the calendar quarter following the closure of the seller's facility and the surrender of the seller's licensed beds to the department. The per diem will be calculated as the buyer's annual Medicaid incentive payment as defined under §1312.C.3 divided by annual Medicaid days. Annual Medicaid days will be equal to Medicaid residents transferred from the seller facility, as determined under §1312.B.5.a, multiplied by total current rate year days plus the buyer's annualized Medicaid days from the most recent base year cost report. If the most recent base year cost report includes or overlaps the period of the transfer, an adjustment will be made to avoid including the transferred days twice.

2. The revised fair rental value per diem and revised property tax and insurance per diem for the buyer(s) will be effective the first day of the month following the closure of the acquired facility (seller).

3. The incentive per diems, the revised fair rental value per diem, and revised property tax and insurance per diem will be updated at every case-mix rebase effective date.

4. The incentive payments when combined with all other Medicaid nursing facility payments shall not exceed the Medicare upper payment limit.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 33:1349 (July 2007), amended LR 34:1033 (June 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:528 (March 2017).

§20013. Case-Mix Documentation Reviews and Case-Mix Index Reports [Formerly LAC 50:VII.1313]

A. The department shall provide each nursing facility provider with the preliminary case-mix index report (PCIR) by approximately the fifteenth day of the second month following the beginning of a calendar quarter. The PCIR will serve as notice of the MDS assessments transmitted and provide an opportunity for the nursing facility provider to correct and transmit any missing MDS assessments or tracking records or apply the CMS correction request process where applicable. The department shall provide each nursing facility provider with a final case-mix index report (FCIR) utilizing MDS assessments after allowing the nursing facility providers a reasonable amount of time to process their corrections (approximately two weeks).

1. If the department determines that a nursing facility provider has delinquent MDS resident assessments, for purposes of determining both average CMIs, such assessments shall be assigned the case-mix index associated with the RUG-III group "BC1-delinquent" or its successor. A delinquent MDS shall be assigned a CMI value equal to the lowest CMI in the RUG-III, or its successor, classification system.

B. The department shall periodically review the MDS supporting documentation maintained by nursing facility providers for all residents, regardless of payer type. Such reviews shall be conducted as frequently as deemed necessary by the department. The department shall notify nursing facility providers of the scheduled case-mix documentation reviews (CMDR) not less than two business days prior to the start of the review date and a fax, electronic mail or other form of communication will be provided to the administrator or other nursing facility provider designee on the same date identifying possible documentation that will be required to be available at the start of the on-site CMDR.

1. The department shall review a sample of MDS resident assessments equal to the greater of 20 percent of the occupied bed size of the nursing facility or 10 assessments and shall include those transmitted assessments posted on the most current FCIR. The CMDR will determine the percentage of assessments in the sample that are unsupported MDS resident assessments. The department may review additional or alternative MDS assessments, if it is deemed necessary.

2. When conducting the CMDR, the department shall consider all MDS supporting documentation that is provided by the nursing facility provider and is available to the RN reviewers prior to the start of the exit conference. MDS supporting documentation that is provided by the nursing facility provider after the start of the exit conference shall not be considered for the CMDR.

3. Upon request by the department, the nursing facility provider shall be required to produce a computer-generated copy of the MDS assessment which shall be the basis for the CMDR.

4. After the close of the CMDR, the department will submit its findings in a summary review results (SRR) letter to the nursing facility within 10 business days following the final exit conference date.

5. The following corrective action will apply to those nursing facility providers with unsupported MDS resident assessments identified during an on-site CMDR.

a. If the percentage of unsupported assessments in the initial on-site CMDR sample is greater than 20 percent, the sample shall be expanded, and shall include the greater of 20 percent of the remaining resident assessments or 10 assessments.

b. If the percentage of unsupported MDS assessments in the total sample is equal to or less than the threshold percentage as shown in column (B) of the table in Subparagraph e below, no corrective action will be applied.

c. If the percentage of unsupported MDS assessments in the total sample is greater than the threshold percentage as shown in column (B) of the table in Subparagraph e below, the RUG-III, or its successor, classification shall be recalculated for the unsupported MDS assessments based upon the available documentation obtained during the CMDR process. The nursing facility provider's CMI and resulting Medicaid rate shall be recalculated for the quarter in which the FCIR was used to determine the Medicaid rate. A follow-up CMDR process described in Subparagraphs d and e may be utilized at the discretion of the department.

d. Those nursing facility providers exceeding the thresholds (see column (B) of the table in Subparagraph e) during the initial on-site CMDR will be given 90 days to correct their assessing and documentation processes. A follow-up CMDR may be performed at the discretion of the department at least 30 days after the nursing facility provider's 90-day correction period. The department or its contractor shall notify the nursing facility provider not less than two business days prior to the start of the CMDR date. A fax, electronic mail, or other form of communication will be provided to the administrator or other nursing facility provider designee on the same date identifying documentation that must be available at the start of the on-site CMDR.

e. After the follow-up CMDR, if the percentage of unsupported MDS assessments in the total sample is greater than the threshold percentage as shown in column (B) of the following table, the RUG-III, or its successor, classification shall be recalculated for the unsupported MDS assessments based upon the available documentation obtained during the CMDR process. The nursing facility provider's CMI and resulting Medicaid rate shall be recalculated for the quarter in which the FCIR was used to determine the Medicaid rate. In addition, facilities found to have unsupported MDS resident assessments in excess of the threshold in column (B) of the table below may be required to enter into a documentation improvement plan with the department. Additional follow-up CMDR may be conducted at the discretion of the department.

Effective Date (A)	Threshold Percent (B)
January 1, 2003	Educational
January 1, 2004	40%
January 1, 2005	35%
January 1, 2006	25%
February 20, 2019 and beyond	20%

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2537 (December 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:826 (March 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:528 (March 2017), LR 45:274 (February 2019).

§20015. Appeal Process [Formerly LAC 50:VII.1315]

A. If the facility disagrees with the CMDR findings, a written request for an informal reconsideration must be submitted to the department within 15 business days of the facility's receipt of the CMDR findings in the SRR letter. Otherwise, the results of the CMDR findings are considered final and not subject to appeal. The department will review the facility's informal reconsideration request within 10 business days of receipt of the request and will send written notification of the final results of the reconsideration to the facility. No appeal of findings will be accepted until after communication of final results of the informal reconsideration process.

B. The provider has the right to request an appeal within 30 days of the written notice of the results of the informal reconsideration. Such request must be in writing to the Appeals Section. The request must contain a statement and be accompanied by supporting documents setting forth with particularity those asserted discrepancies which the provider contends are in compliance with the agency's regulations and the reasons for such contentions.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 28:2538 (December 2002), amended by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 38:827 (March 2012), amended by the Department of Health, Bureau of Health Services Financing, LR 43:529 (March 2017).

§20017. Reimbursement for Fire Sprinkler Systems and Two-Hour Rated Wall Installations [Formerly LAC 50:VII.1317]

A. All nursing facilities are required to be protected throughout by a fire sprinkler system by January 1, 2008. Where means of egress passes through building areas outside of a nursing facility, those areas shall be separated from the nursing facility by a two-hour rated wall or shall be protected by a fire sprinkler system.

B. Nursing Facility Procedure and Documentation Requirements

1. A completed fire sprinkler system plan or two-hour rated wall plan, or both, must be submitted to the department for review and approval by December 31, 2006.

2. Upon approval of the plans and after installation is completed, nursing facilities must submit auditable depreciation schedules and invoices to support the installation cost of all fire sprinkler systems and two-hour rated walls. The documentation must be submitted to the department or its designee.

a. All supporting documentation, including depreciation schedules and invoices, must indicate if the cost was previously included in a fair rental value re-age request.

C. Medicaid participating nursing facilities that install or extend fire sprinkler systems or two-hour rated walls, or both, after August 1, 2001, and in accordance with this section, may receive Medicaid reimbursement for the cost of installation over a five year period beginning the later of July 1, 2007 or the date of installation. The Medicaid reimbursement shall be determined as follows.

1. The annual total reimbursable cost is equal to a nursing facility's total installation cost of all qualified fire sprinkler systems and two-hour rated walls divided by five.

2. The per diem cost is calculated as the annual total reimbursable cost divided by total nursing facility resident days as determined by the nursing facility's most recently audited or desk reviewed Medicaid cost report as of April 30, 2007. If a cost report is not available, current nursing facility resident day census records may be used at the department's approval.

3. The per diem cost is reduced by any fair rental value per diem increase previously recognized as a result of the costs being reimbursed under this section. This adjusted per diem cost shall be paid to each qualifying nursing facility as and additional component of their Medicaid daily rate for five years.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 32:2266 (December 2006).

§20019. Evacuation and Temporary Sheltering Costs [Formerly LAC 50:VII.1319]

A. Nursing facilities required to participate in an evacuation, as directed by the appropriate parish or state official, or which act as a host shelter site may be entitled to reimbursement of its documented and allowable evacuation and temporary sheltering costs.

1. The expense incurred must be in excess of any existing or anticipated reimbursement from any other sources, including the Federal Emergency Management Agency (FEMA) or its successor.

2. Nursing facilities must first apply for evacuation or sheltering reimbursement from all other sources and request that the department apply for FEMA assistance on their behalf.

3. Nursing facilities must submit expense and reimbursement documentation directly related to the evacuation or temporary sheltering of Medicaid nursing home residents to the department.

B. Eligible Expenses. Expenses eligible for reimbursement must occur as a result of an evacuation and be reasonable, necessary, and proper. Eligible expenses are subject to audit at the department's discretion and may include the following.

1. Evacuation Expenses. Evacuation expenses include expenses from the date of evacuation to the date of arrival at a temporary shelter or another nursing facility. Evacuation expenses include:

a. resident transportation and lodging expenses during travel;

b. nursing staff expenses when accompanying residents, including:

i. transportation;

ii. lodging; and

iii. additional direct care expenses, when a direct care expense increase of 10 percent or more is documented:

(a). the direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department;

c. any additional allowable costs as defined in the CMS Publication 15-1-21, last modified 9/28/2012, that are directly related to the evacuation and that would normally be allowed under the nursing facility case-mix rate.

2. Non-Nursing Facility Temporary Sheltering Expenses. Non-nursing facility temporary sheltering expenses include expenses from the date the Medicaid residents arrive at a non-nursing facility temporary shelter to

the date all Medicaid residents leave the shelter. A non-nursing facility temporary shelter includes shelters that are not part of a licensed nursing facility and are not billing for the residents under the Medicaid case-mix reimbursement system or any other Medicaid reimbursement system. Non-nursing facility temporary sheltering expenses may include:

a. additional nursing staff expenses including:

i. lodging; and

ii. additional direct care expenses, when a direct care expense increase of 10 percent or more is documented:

(a). the direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department;

b. care-related expenses as defined in LAC 50:II.20005 and incurred in excess of care-related expenses prior to the evacuation;

c. additional medically necessary equipment such as beds and portable ventilators that are not available from the evacuating nursing facility and are rented or purchased specifically for the temporary sheltered residents, and:

i. these expenses will be capped at a daily rental fee not to exceed the total purchase price of the item;

ii. the allowable daily rental fee will be determined by the department;

d. any additional allowable costs as defined in the CMS Publication 15-1-21, last modified 9/28/2012, that are directly related to the temporary sheltering and that would normally be allowed under the nursing facility case-mix rate.

3. Host Nursing Facility Temporary Sheltering Expenses. Host nursing facility temporary sheltering expenses include expenses from the date the Medicaid residents are admitted to a licensed nursing facility to the date all temporary sheltered Medicaid residents are discharged from the nursing facility, not to exceed a six-month period.

a. The host nursing facility shall bill for the residents under Medicaid's case-mix reimbursement system.

b. Additional direct care expenses may be submitted when a direct care expense increase of 10 percent or more is documented.

i. The direct care expense increase must be based on a comparison to the average of the previous two pay periods or other period comparisons determined acceptable by the department.

C. Payment of Eligible Expenses

1. For payment purposes, total eligible Medicaid expenses will be the sum of nonresident-specific eligible expenses multiplied by the facility's Medicaid occupancy percentage plus Medicaid resident-specific expenses.

a. If Medicaid occupancy is not easily verified using the evacuation resident listing, the Medicaid occupancy from the most recently filed cost report will be used.

2. Payments shall be made as quarterly lump-sum payments until all eligible expenses have been submitted and paid. Eligible expense documentation must be submitted to the department by the end of each calendar quarter.

3. All eligible expenses documented and allowed under §20019 will be removed from allowable expenses when the nursing facility's Medicaid cost report is filed. These expenses will not be included in the allowable cost used to set case-mix reimbursement rates in future years.

a. Equipment purchases that are reimbursed on a rental rate under §20019.B.2.c may have their remaining basis included as allowable cost on future costs reports provided that the equipment is in the nursing facility and being used. If the remaining basis requires capitalization under CMS Publication 15-1-21 guidelines, last modified 9/28/2012, then depreciation will be recognized.

4. Payments shall remain under the upper payment limit cap for nursing facilities.

D. When a nursing facility (NF) resident is evacuated to a temporary shelter site (an unlicensed sheltering site or a licensed NF) for less than 24 hours, the Medicaid vendor payment to the evacuating facility will not be interrupted.

E. When an NF resident is evacuated to a temporary shelter site (an unlicensed sheltering site or a licensed NF) for greater than 24 hours, the evacuating nursing facility may submit the claim for Medicaid vendor payment for a maximum of five days, provided that the evacuating nursing facility provides sufficient staff and resources to ensure the delivery of essential care and services to the resident at the temporary shelter site.

F. When an NF resident is evacuated to a temporary shelter site, which is an unlicensed sheltering site, for greater than five days, the evacuating nursing facility may submit the claim for Medicaid vendor payment for up to an additional 15 days, provided that the evacuating nursing facility:

1. has received an extension to stay at the unlicensed shelter site; and

2. provides sufficient staff and resources to ensure the delivery of essential care and services to the resident, and to ensure the needs of the resident are met.

G. When an NF resident is evacuated to a temporary shelter site, which is a licensed nursing home, for greater than five days, the evacuating nursing facility may submit the claim for Medicaid vendor payment for an additional period, not to exceed 55 days, provided that:

1. the host/receiving nursing home has sufficient licensed and certified bed capacity for the resident, or the host/receiving nursing home has received departmental and/or CMS approval to exceed the licensed and certified bed capacity for a specified period; and

2. the evacuating nursing facility provides sufficient staff and resources to ensure the delivery of essential care and services to the resident, and to ensure the needs of the resident are met.

H. If an NF resident is evacuated to a temporary shelter site which is a licensed NF, the receiving/host nursing home may submit claims for Medicaid vendor payment under the following conditions:

1. beginning day two and continuing during the "sheltering period" and any extension period, if the evacuating nursing home does not provide sufficient staff and resources to ensure the delivery of essential care and services to the resident and to ensure the needs of the residents are met;

2. upon admission of the evacuated residents to the host/receiving nursing facility; or

3. upon obtaining approval of a temporary hardship exception from the department, if the evacuating NF is not submitting claims for Medicaid vendor payment.

I. Only one nursing facility may submit the claims and be reimbursed by the Medicaid Program for each Medicaid resident for the same date of service.

J. A nursing facility may not submit claims for Medicaid vendor payment for non-admitted residents beyond the expiration of its extension to exceed licensed (and/or certified) bed capacity or expiration of its temporary hardship exception.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Office of the Secretary, Bureau of Health Services Financing, LR 34:879 (May 2008), amended by the Department of Health, Bureau of Health Services Financing, LR 43:328 (February 2017).

§20021. Leave of Absence Days [Formerly LAC 50:VII.1321]

A. For each Medicaid recipient, nursing facilities shall be reimbursed for up to seven hospital leave of absence days per occurrence and 15 home leave of absence days per year.

B. The reimbursement for hospital leave of absence days is 75 percent of the applicable per diem rate.

C. Nursing facilities with occupancy rates less than 90 percent. Effective for dates of service on or after February 20, 2009, reimbursement for hospital and home leave of absence days will be reduced to 10 percent of the applicable per diem rate in addition to the nursing facility provider fee.

D. Nursing facilities with occupancy rates equal to or greater than 90 percent. Effective for dates of service on or after February 20, 2009, the reimbursement paid for home leave of absence days will be reduced to 90 percent of the applicable per diem rate, which includes the nursing facility provider fee.

1. Effective for dates of service on or after March 1, 2009, the reimbursement for hospital leave of absence days for nursing facilities with occupancy rates equal to or greater than 90 percent shall be 90 percent of the applicable per diem rate, which includes the nursing facility provider fee.

E. Occupancy percentages will be determined from the average annual occupancy rate as reflected in the Louisiana Inventory of Nursing Home Bed Utilization Report published from the period six months prior to the beginning of the current rate quarter. Occupancy percentages will be updated quarterly when new rates are loaded and shall be in effect for the entire quarter.

F. Effective for dates of service on or after July 1, 2013, the reimbursement paid for leave of absence days shall be 10 percent of the applicable per diem rate in addition to the provider fee amount.

1. The provider fee amount shall be excluded from the calculations when determining the leave of absence days payment amount.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 35:1899 (September 2009), amended LR 41:133 (January 2015).

§20023. Transition of State-Owned or Operated Nursing Facility to a Private Facility

A. A state owned or operated nursing facility that changes ownership (CHOW) in order to transition to a private nursing facility will be exempt from the case-mix direct care and care-related spending floor for a period of 12 months following the effective date of the CHOW under the following conditions:

1. the state-owned or operated facility is located in the DHH administrative region 1; and

2. the change of ownership is the result of a leasing arrangement.

B. Cost Reports

1. The previous owner of the nursing facility must file a closing cost report within 60 days of the CHOW for the time period that spans from the beginning of the facility's cost report period to the date of the CHOW.

2. The initial cost report period following the CHOW will be determined based on the elected fiscal year end of the new facility.

3. The closing and initial cost reports must be filed in accordance with the provisions of §20003, including the filing of all Medicaid supplemental schedules.

C. A capital data survey must be filed with the department within 60 days of the effective date of the CHOW. The capital data survey must include the nursing facility's date of construction, current square footage, and all renovations made since the facility's opening.

D. Rate Determination

1. During the transition period (12 months following the effective date of the change of ownership), the Medicaid

reimbursement rate for the transitioned nursing facility shall be the per diem rate on file as of March 19, 2010 for the state-owned or operated facility.

2. The transitioned nursing facility will be transferred to the case-mix reimbursement system at the end of the 12 month transition period.

3. The Medicaid reimbursement rate and direct care/care-related floor shall be calculated in accordance with the provisions of §20005.

a. The direct care/care-related floor will be effective on the date of transition to the case mix reimbursement system.

b. For purposes of this initial floor calculation, direct care and care-related spending will be determined by apportioning cost report period costs based on calendar days.

4. Under the case mix reimbursement methodology, the facility will file cost reports in accordance with the provisions of §20003, including all Medicaid supplemental schedules.

a. If the nursing facility's cost report period overlaps the date of transition to the case mix reimbursement methodology, the case mix direct care and care-related floor will only be applied to the portion of the cost report period that occurs after the date of transition to case mix.

5. Until the nursing facility has an audited or desk reviewed cost report that is available for use in a case mix rebase in accordance with the provisions of §20005.B, the case mix reimbursement rate components will be based on the following criteria except as noted in Subsection D.6 of this Section.

a. The facility's acuity as determined from its specific case mix index report for the quarter prior to the effective date of the rate.

b. The direct care and care-related statewide median prices in effect for that period.

i. The statewide direct care and care related price shall be apportioned between the per diem direct care component and the per diem care related component using the nursing facility's most recent non-disclaimed audited or desk reviewed cost report.

ii. The facility-specific percentages will be determined using the methodology described in §20005.D.1.c.

c. The administrative and operating statewide median prices in effect for that period.

d. The capital data for the fair rental value rate component will be calculated from the facility-submitted capital data survey and the occupancy percentage from the most recent non-disclaimed audited or desk reviewed cost report as of the effective date of the rate.

e. The facility's property insurance cost will be calculated from the most recent non-disclaimed audited or desk reviewed cost report as of the rate effective date.

f. The property tax cost will be collected in the form of an interim property tax report specified by the department.

i. The interim property tax report must be filed within 30 days after the beginning of the nursing facility's cost reporting period.

ii. Failure to provide the interim property tax report within the specified time frame will result in a $0 reimbursement rate for the property tax rate component.

iii. The facility must continue to file an interim property tax report until the facility is able to produce a non-disclaimed audited or desk reviewed cost report that contains property tax cost.

g. Provider fee and budget adjustments in effect for all other case mix facilities will be applicable.

6. A disclaimed cost report that would otherwise be used in a rebase will result in a rate calculated in accordance with the provisions of §20011 and the provisions contained in Subsection D.3.a-b and D.4.a of this Section will no longer be applicable.

7. If additional data is needed, the department may request that the facility submit Medicaid supplemental cost report schedules for those cost report period year ends for which the facility has not previously submitted Medicaid supplemental schedules.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 37:903 (March 2011), amended by the Department of Health, Bureau of Health Services Financing, LR 45:275 (February 2019).

§20024. Transition of Private Nursing Facility to a State-Owned or Operated Nursing Facility through a Change of Ownership

A. Any private nursing facility that undergoes a change of ownership (CHOW) to a state-owned or operated nursing facility will be exempt from the prospective reimbursement system for public nursing facilities during the transitional period.

1. The transitional period will be effective from the date of the CHOW until the July 1 rate setting period following when the state-owned or operated nursing facility has an audited or reviewed 12 month or greater cost reporting period available for use in rate setting.

2. After the transitional period, the nursing facility will be reimbursed pursuant to the requirements of the prospective reimbursement system for public nursing facilities.

B. Effective for dates of service on or after July 5, 2018, the reimbursement amount paid to a public nursing facility during the transitional period shall be as follows:

1. Public nursing facilities transitioning from private ownership shall receive a monthly interim payment based on occupancy, which shall be a per diem rate of $365.68.

2. For each cost reporting period ending during the transitional period a cost settlement process shall be performed. The cost settlement process shall ensure that Medicaid reimbursement for each public nursing facility transitioning from private ownership is equal to 100 percent of the nursing facility's Medicaid allowable cost for the applicable cost reporting period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 45:275 (February 2019).

§20025. Low Income and Needy Care Collaboration

A. Effective for dates of service on or after November 1, 2011, quarterly supplemental payments shall be issued to qualifying nursing facilities for services rendered during the quarter. Maximum aggregate payments to all qualifying nursing facilities shall not exceed the available upper payment limit per state fiscal year.

B. Qualifying Criteria. In order to qualify for the supplemental payment, the nursing facility must be affiliated with a state or local governmental entity through a low income and needy care nursing facility collaboration agreement.

1. A nursing facility is defined as a currently licensed and certified nursing facility which is owned or operated by a private entity or non-state governmental entity.

2. A low income and needy care nursing facility collaboration agreement is defined as an agreement between a nursing facility and a state or local governmental entity to collaborate for purposes of providing healthcare services to low income and needy patients.

C. Each qualifying nursing facility shall receive quarterly supplemental payments for nursing facility services. Quarterly payment distribution shall be limited to one-fourth of the aggregated difference between each qualifying nursing facility's Medicare rate and Medicaid payments the nursing facility receives for covered services provided to Medicaid recipients during a 12 consecutive month period. Medicare rates in effect for the dates of service included in the supplemental payment period will be used to establish the upper payment limit. Medicaid payments will be used for the same time period.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:793 (April 2014).

§20026. Geriatric Training Nursing Facility Reimbursement Rate

Note: The provisions of this Section shall be subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) of a State Plan amendment authorizing such payment.

A. Effective for dates of service on or after July 1, 2019, LDH shall provide a private nursing facility reimbursement rate of $365.68 per resident per day to an entity that meets the following criteria:

1. the entity has a cooperative endeavor agreement (CEA) with Louisiana State University (LSU) to operate the current John J. Hainkel, Jr. Home and Rehabilitation Center or any future location used to operate John J. Hainkel, Jr. Home and Rehabilitation Center which has been approved by the parties and the department, as a geriatric training nursing facility.

B. The private nursing facility reimbursement rate established in Subsection A above is all-inclusive.

1. Add-ons, including, but not limited to, technology dependent care (TDC), nursing facility rehabilitation services and nursing facility complex care services add-ons shall not be permitted under this reimbursement rate.

C. Any nursing facility that meets the criteria set forth in Subsection A above shall file an annual cost report with LDH within five months following the end of the facility's fiscal year.

D. The provisions of this Rule shall be subject to approval by the U.S. Department of Health and Human Services, Centers for Medicare and Medicaid Services (CMS) of a State Plan amendment authorizing such payment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health, Bureau of Health Services Financing, LR 45:756 (June 2019), repromulgated LR 45:909 (July 2019).

§20027. Specialized Care Reimbursement

A. A specialized care reimbursement rate shall consist of a nursing facility's Medicaid case-mix reimbursement rate plus an add-on amount. These rates can be established by the department for a specialized care unit.

B. Nursing Facility Specialized Care Unit Reimbursement

1. Effective with the January 1, 2014 rate period, infectious disease (ID) specialized care costs will no longer be reimbursed through a separate per diem add-on payment. ID costs and days will be included in the calculation of the case-mix nursing facility reimbursement rates and the direct care and care-related floor calculation as described under §20005 of this Chapter.

2. Effective with the January 1, 2014 rate period, technologically dependent care (TDC) costs and days will be included in the calculation of the case-mix nursing facility reimbursement rates and the direct care and care-related floor calculation as described under §20005 of this Chapter. TDC services will continue to be reimbursed through a separate per diem add-on payment. The department will be solely responsible for determining adjustments to the TDC per diem add-on payment.

3. Effective with the January 1, 2014 rate period, Neurological Rehabilitation Treatment Program (NRTP)

costs and days for both rehabilitative and complex services will be included in the calculation of the case-mix nursing facility reimbursement rates and the direct care and care-related floor calculation as described under §20005 of this Chapter. NRTP services will be reimbursed through a separate per diem add-on payment. The department will be solely responsible for determining adjustments to the NRTP per diem add-on payment.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254, R.S. 46:2742, and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 40:541 (March 2014).

§20029. Supplemental Payments

A. Non-State Governmental Organization Nursing Facilities

1. Effective for dates of service on or after January 20, 2016, any nursing facility that is owned or operated by a non-state governmental organization (NSGO), and that has entered into an agreement with the department to participate, shall qualify for a Medicaid supplemental payment adjustment, in addition to the uniform Medicaid rates paid to nursing facilities. The only qualifying nursing facilities effective for January 20, 2016 are:

a. Gueydan Memorial Guest Home;

b. Lane Memorial Hospital Geriatric Long-Term Care (LTC);

c. LaSalle Nursing Home;

d. Natchitoches Parish Hospital LTC Unit; and

e. St. Helena Parish Nursing Home.

2. The supplemental Medicaid payment to a non-state, government-owned or operated nursing facility shall not exceed the facility's upper payment limit (UPL) pursuant to 42 CFR 447.272.

3. Payment Calculations. The Medicaid supplemental payment for each state fiscal year (SFY) shall be calculated immediately following the July quarterly Medicaid rate setting process. The total Medicaid supplemental payment for each individual NSGO will be established as the individual nursing facility differential between the estimated Medicare payments for Medicaid nursing facility residents, and the adjusted Medicaid payments for those same nursing facility residents. A more detailed description of the Medicaid supplemental payment process is described below.

a. The calculation of the total annual Medicaid supplemental payment for nursing facilities involves the following four components:

i. calculate Medicare payments for Louisiana Medicaid nursing facility residents using Medicare payment principles;

ii. determining Medicaid payments for Louisiana Medicaid nursing facility residents;

iii. adjust payments for coverage difference between Medicare payment principles and Louisiana Medicaid payment principles; and

iv. calculating the differential between the calculated Medicare payments for Medicaid nursing facility residents, and Medicaid payments for those same residents.

b. Calculating Medicaid Rates Using Medicare Payment Principles. With Medicare moving to the prospective payment system (PPS), Medicare rates will be calculated based on Medicaid acuity data. The following is a summary of the steps involved.

i. Using each resident's minimum data set assessment, the applicable RUG-III grouper code for Medicaid residents was identified. A frequency distribution of Medicaid residents in each of the Medicare RUG classification categories is then generated.

(a). The resident minimum data set assessments will be from the most recently available minimum data set assessments utilized in Medicaid rate setting processes as of the development of the Medicaid supplemental payment calculation demonstration.

ii. After the Medicaid resident frequency distribution was developed, rural and urban rate differentials and wage index adjustments will be used to adjust the Medicare rate tables. Medicare rate tables will be applicable to SFY periods.

(a). Medicare rate tables will be established using information published in 42 CFR part 483 where available. Should the finalized Medicare rate tables for any portion of the applicable SFY period be unavailable, the most recent preliminary Medicare rate adjustment percentage published in the *Federal Register* available as of the development of the Medicaid supplemental payment calculation demonstration will be utilized as the basis of the Medicare rate for that portion of the SFY period.

(b). The resulting Medicare rates are multiplied by the number of Medicaid residents in each RUG category, summed and then averaged. The Medicare rate tables applicable to each period of the SFY will be multiplied by an estimate of Medicaid paid claims days for the specified period. Medicaid paid claims days will be compiled from the state's Medicaid Management Information System's (MMIS) most recent 12 months, as of the development of the Medicaid supplemental payment calculation demonstration.

c. Determining Medicaid Payments for Louisiana Medicaid Nursing Facility Residents. The most current Medicaid nursing facility reimbursement rates as of the development of Medicaid supplemental payment calculation demonstration will be utilized. These reimbursement rates will be multiplied by Medicaid paid claims compiled from the state's MMIS system from the most recent 12 months, as of the development of the Medicaid supplemental payment calculation demonstration, to establish total Medicaid per diem payments. Total calculated Medicaid payments made outside of the standard nursing facility per diem are summed with total Medicaid reimbursement from the per diem

payments to establish total Medicaid payments. Payments made outside of the standard nursing facility per diem are reimbursement for the following services.

i. Specialized Care Services Payments. Specialized care services reimbursement is paid outside of the standard per diem rate as an add-on payment to the current facility per diem rate. The established specialized care add-on per diems will be multiplied by Medicaid paid claims for specialized care days compiled from the state's MMIS system from the most recent 12 months, as of the development of the Medicaid supplemental payment calculation demonstration, to establish projected specialized care services payments for the applicable SFY.

ii. Home/Hospital Leave Day (Bed Hold) Payments. Allowable Medicaid leave days were established using Medicaid paid claims days compiled from the state's MMIS system from the most recent 12 months, as of the development of the Medicaid supplemental payment calculation demonstration. Allowable Medicaid Leave days will be multiplied by the most recent Medicaid leave day quarterly reimbursement rates as of the of the Medicaid supplemental payment calculation demonstration to established projected Medicaid Leave day payments for the SFY.

iii. Private Room Conversion Payments. Private room conversion (PRC) Medicaid days will be established utilizing the most recently reviewed or audited Medicaid supplemental cost reports as of the development of the Medicaid supplemental payment calculation demonstration. The applicable cost reporting period information will be annualized to account for short year cost reporting periods. Allowable PRC Medicaid days will be multiplied by the PRC incentive payment amount of $5 per allowable day to establish the total projected Medicaid PRC payments for the SFY.

d. Adjusting for Differences between Medicare Principles and Louisiana Medicaid Nursing Facility Residents. An adjustment to the calculation of the Medicaid supplemental payment limit will be performed to account for the differences in coverage between the Medicare PPS rate and what Louisiana Medicaid covers within the daily rate provided above. To accomplish this, an estimate will be calculated for pharmacy, laboratory, and radiology claims that were paid on behalf of nursing facility residents for other than their routine daily care. These estimates will then be added to the total calculated Medicaid payments.

e. Calculating the Differential Between the Calculated Medicare Payments for Medicaid Nursing Facility Residents, and Medicaid Payments for Those Same Residents. The total annual Medicaid supplemental payment will be equal to the individual NSGO nursing facility's differential between their calculated Medicare payments and the calculated adjusted Medicaid payments for the applicable SFY, as detailed in the sections above.

4. Frequency of Payments and Calculations. The Medicaid supplemental payments will be reimbursed through a calendar quarter based lump sum payment. The amount of the calendar quarter lump sum payment will be equal to the SFY total annual Medicaid supplemental payment divided by four. The total annual Medicaid supplemental payment calculation will be performed for each SFY immediately following the July quarterly Medicaid rate setting process.

5. No payment under this section is dependent on any agreement or arrangement for provider or related entities to donate money or services to a governmental entity.

AUTHORITY NOTE: Promulgated in accordance with R.S. 36:254 and Title XIX of the Social Security Act.

HISTORICAL NOTE: Promulgated by the Department of Health and Hospitals, Bureau of Health Services Financing, LR 42:63 (January 2016), amended by the Department of Health, Bureau of Health Services Financing, LR 43:529 (March 2017).